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April 1991

Volume 74, Number 4



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Seebert J. Goldowsky, MD*



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RHODE ISLAND MEDICAL JOURNAL



Volume 74, Number 4

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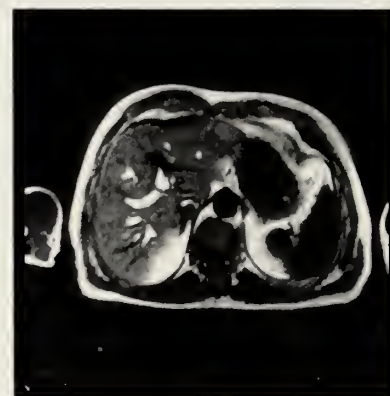
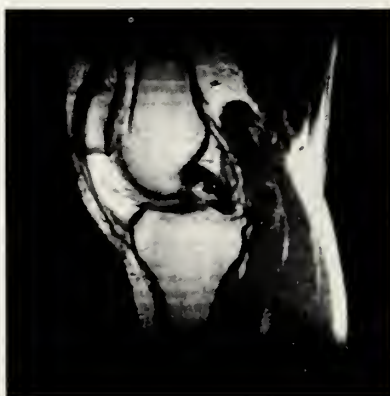
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Cover: This month's cover illustration is an oil painting by the eminent surgeon-artist, Joe Wilder, MD, entitled "Contemplation Before Surgery".

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EDITORIALS

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Best Wishes, Friend

Doctor Seebert J. Goldowsky became a Fellow of the Rhode Island Medical Society in 1936. I don't remember his first visit to the Library but I have a vivid memory of the scene into which he walked. He climbed the granite steps, entered the vestibule and opened the door into the foyer. From there he could look into the reading room, for the huge wooden door hidden in the wall was seldom pulled out to block the entrance. As a matter of fact, the door is there still for it was left in place when the area was remodelled.

If he came to check current literature, he found the most recent subscription journals on the large oak table in the center of the room; exchange periodicals were arranged on the case against the back wall. He could sit at all but one of the six study tables arranged around the room, each placed in front of a window to take advantage of daylight, each with a lamp for use after dark. The bay window was the home of a large palm, handsome to behold but heartily disliked by the janitor who had to wash each and every leaf twice a year. When we

started having commercial exhibits during the annual meeting of the Society, the palm was sent to a greenhouse, and after several trips, perished. The table that was not available to readers was the last one on the Hayes Street site and this was Librarian Grace Dickerman's working desk. Sometimes she shared it with Blackie, the resident feline.

Perhaps he came to use the current textbooks. In that case, he went from the foyer directly into the librarian's "office". This was an alcove, part of the reading room. The books were shelved against the rear wall. There was a very ancient roll-top desk in the office which Grace and I used for supplies, records, and whatever. The only person who used it as a desk was the Treasurer, Doctor Jesse E. Mowry, when he signed checks.

Grace might have been collating journals or posting dues and making financial records. There was no executive office so the library staff (two) were librarians, secretaries, bookkeepers, writers of reports, and custodians. I might have been using the Index Medicus,

doing a search for one of the members. It is more likely, though, that I was typing away on the old Royal, continuing the cataloguing that I had begun in late 1932. All of the bound journals on the first floor were finished and I had started on the many monographs. The typewriter table, during warm weather, was just around the corner by the entrance to the stacks; in winter I typed with my back to the radiator in the rear of the stacks.

Of course, Doctor Goldowsky might have turned right after entering the foyer, mounted the marble steps, and turned right again to enter the Miller Room. This room was named in honor of Horace G. Miller, who had been a supporter of the library, Chairman of the Library Committee for several years, and donor of his magnificent collection of ENT books and journals. Several of the most valuable items were on the shelves of this room. The James Henry Davenport Collection occupied the other shelves and the glass-fronted, locked cabinet containing our rare books stood on the opposite wall. His survey of the Library would have ended

here as the next level was the auditorium. There were no offices then and the alcoves were part of the main room. The chairs in the auditorium were wooden, practical, but neither comfortable nor attractive. There were no draperies (and none in the Reading Room) and the only decorations were the Society's seal above the stage, and a few paintings.

The good doctor could have continued his survey by opening what seemed to be a mirror on the right hand side and climbing into the top floor of the stacks. He would have been appalled at the confusion. It would be many years before any sort of order would be made of this particular chaos of unbound periodicals.

When he returned to the Reading Room, he might have found Grace working on the figures for the financial report of the *Rhode Island Medical Journal*, writing in her neat hand, getting it ready for me to type a copy for publication in the Annual Report.

Librarian George Dallas Hersey, MD, considered the Society's publication and its library to be partners, each serving the other. He had been an editor of the *Transactions* and was the first editor of the *Providence Medical Journal* which he said would be a source of exchanges and review books, thus building library holdings. It was understood from the beginning that the volumes sent to the *Journal* were to be returned to the

Library and not kept by the reviewer. Usually, they were.

We carried on Doctor Hersey's tradition but, for many years our duties were minimal, consisting of getting House of Delegates and Council reports ready for printing (even ghosting an occasional report), keeping the printer advised as to additions, subtractions, and corrections to the mailing list, billing, and binding, and other routine matters.

When Seebert became editor the Library staff became much more involved with the *Rhode Island Medical Journal*. I had spent many months on a project that involved finding original articles on various syndromes. I found that citations were often incorrect: when the first author added the original to his bibliography and made an error, the error was carried forward by each succeeding author. And there was no consistency in the manner in which the citations were written. These discoveries resulted in our checking every reference given in a paper submitted to the *Journal* and in using a uniform pattern.

Another duty was added when I happened to mention to Seebert that I found the very abbreviated indexes in early volumes of our *Journal* inadequate for research. I did not mind reading a whole volume to find one fact but it took quite a lot of time. He suggested that I take over the indexing. And there was the Book Review work: getting a reviewer, getting the

review, getting the book returned. An occasional editorial was suggested. Doctor Hersey would have been pleased with the close cooperation of library and periodical.

So I contributed in a small way to the *Rhode Island Medical Journal* and its Editor from 1960 to 1989 was a major contributor to the Library and to its Librarian. He achieved frequent-reader status rapidly as our Library became a busy post-war reference source. His research for "The First Fifty Years" in *The History of the Rhode Island Medical Society and its Component Societies* was done in the Dickerman Room. He endured the dust in the stacks so that he could search several volumes without our having to bring them down. He delighted in history and found past performers real people as I did. And you soon learned that any answer you gave had to have proof.

At the second meeting of the New England Group Medical Library Association in 1959, we asked Seebert to be the dinner speaker. His "Life and Times of Mary Edwards Walker, a Contract Surgeon During the Civil War" was a fascinating talk.

The rare books so long housed in the big, glass-fronted case were deteriorating and Doctor Goldowsky shared our anxiety about their condition. Some funds became available for the construction of a properly humidified, temperature controlled area in the base-

ment where these precious volumes could be stored. The request to the Council was approved and the room was built. I was told that it was Doctor Goldowsky's suggestion that the plaque on the door read the Helen E. DeJong Rare Book Room. Much of the archival material now in the Society's collection in the Rhode Island Historical Society was given to me for safe-keeping. He is an archivist in addition to his other talents.

He is a top-notch library patron, raconteur, gracious debater, and writer.

Helen E. DeJong
Librarian Emerita

Seebert J. Goldowsky, MD, Physician and Scholar

Some 55 years ago, a young graduate of Harvard Medical School, class of 1932, entered the private practice of general surgery in the Providence region. And in the six subsequent decades, Seebert Goldowsky has enriched the Rhode Island community as a practicing surgeon, a health care administrator, a medical biographer of national stature, and as a diligent editor-in-chief of the *Rhode Island Medical Journal*.

For a span of 29 years, from 1960 to 1989, Goldowsky guided the destiny, content, style and mission of this

Journal. In the pages of 367 issues, and particularly through his countless editorials, he has prodded us, instructed us, humored us, and sometimes shamed us into renewing our commitments to our patients and our honored profession.

The *Journal*, soon to celebrate its seventy-fifth anniversary in January, 1992, has had but four editors-in-chief prior to 1989; Albert H. Miller, a distinguished and innovative anesthesiologist who directed the *Journal* from its inception in 1917 into the depression years; Peter P. Chase, an outstanding surgeon, medical journalist for the lay audience and scholar on the writings of Samuel Johnson; John E. Donley, psychiatrist, authority on forensic matters and a former President of the Rhode Island Medical Society; and Seebert J. Goldowsky, a general surgeon, noted writer and historian. Each of these men has maintained and nurtured the *Journal*, month by month, without ever missing an issue. Each has left an indelible mark upon its literary character, and each has sought out the best in our profession, encouraging us to translate our professional experiences into words (often a wearisome task). Through the sustained efforts of these four leaders, countless intrastate conferences, seminars and orations have been preserved for posterity in the pages of this *Journal*. Because of their labors, the *Journal* has

become, truly, a distinctive archive of our collective accomplishments, concerns, observations and professional priorities, and certainly a uniquely Rhode Island product.

In the first issue of the *Journal* edited by Goldowsky (October, 1960) the readers were offered three related papers on the orthopedic, gynecologic and urologic etiologies of back-ache by Drs Savastano, McDuff and Landsteiner. Additional papers discussed western equine encephalitis (A. Paull), corticoid therapy for rheumatic disease (Simon and Silver) and aldosterone antagonists (Garber). There were editorials in tribute to John Donley, on infant mortality trends in Rhode Island, and on concerns about the unscientific influence of chiropractic therapy in the treatment of poliomyelitis. In his first personal editorial, Goldowsky outlined his intended objectives ("Our main emphasis will be on improving and broadening the scientific scope of the *Journal*.") The fruits of his 29 years of editorial labor far exceeded this modest statement of goals.

This issue, assembled and edited by Helen DeJong, Librarian Emeritus of the Society, contains the collected reminiscences of a few of Seebert Goldowsky's colleagues, some reflecting upon his enduring influence within the Rhode Island community and some illuminating the many unorthodox ways that his colleagues

have engaged themselves in the practice of medicine. These remembrances describe experiences in Haiti, Rumania, Burma (now Myanmar), Kenya, and of course, Rhode Island.

The cover, an oil painting by the prominent contemporary surgeon and artist, Dr Joe Wilder (see editorial in the March, 1991 issue of the *Journal*) is entitled, *Contemplation Before Surgery*. The cover by a surgeon-artist seems particularly fitting as we honor the surgeon-scholar Goldowsky.

The Editorial Board of the *Journal* joyously dedicates this issue, this Festschrift, to Seebert and takes this opportunity to express its profound gratitude to him for his immense gifts he has bestowed upon all of us. We wish Seebert, and his wife Bonnie, many, many years of further scholarly enterprise, good health and personal joy.

Stanley M. Aronson, MD
Kimberly J. Allyn

Rhode Island Physicians in Uniform

Physicians have provided competent medical care for members of the military services whenever our nation has committed itself to the preparation for, or the engagement in, armed conflict. Physicians have rendered this professional care,

not as civilian outsiders offering an occasional consultation, but as fellow service members subjected to the same rigors, restrictions and risks as the rank and file military.

A number of Rhode Island physicians, estimated now to number seven, are currently on active duty in the theater of operations in and around the Persian Gulf.

In the past, when this nation has been at war, the Rhode Island Medical Society has always been supportive of its colleagues in uniform. This past support has taken many tangible forms including:

1. Cancellation of the Society's annual dues until six months after the member has returned to civilian practice in Rhode Island. (In December, 1990, the Council of the Society adopted a similar measure, and extended honorary membership even to those Rhode Island physicians, not currently members, who are about to enter the armed services.)
2. A Society committee to provide consultative assistance to the member after his/her return to civilian status.
3. Keeping the physician informed of local professional and legislative events through periodic mailings of newsletters, bulletins and copies of the *Rhode Island Medical Journal*.

The *Journal*, on behalf of the membership of this Society, expresses the fervent wish that our colleagues in uniform will shortly return safely so that they may again resume their civilian practices in our Rhode Island community.

Stanley M. Aronson, MD
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Seebert Goldowsky, MD – A Prophet in His Own Land

Milton W. Hamolsky, MD

I am honored to participate in this tribute to Seebert Goldowsky. In my considered judgment, he has been, quite simply, one of the truly great medical statesmen of Rhode Island. In my career, I have had the privilege of being exposed to, of meeting, of getting to know the realities of some of the reputed greats of American Medicine. A few have truly deserved the accolade. Seebert has proved – over the years – to be one of the few.

I came to Providence in 1963 because a "blue-ribbon" committee of deans of medical schools had concluded that Brown University and local community hospitals had the potential to develop a new medical school. I found a group of private practicing physicians providing good health care for the community against an inferiority-complex back-drop of "when you're really sick, you go to Boston". I found only one or two certified sub-specialists in the entire spectrum of internal medicine. I found that a large percentage of newly-licensed physicians in the state were

graduates of foreign medical schools, that Rhode Island ranked 48th or 49th in percentage of its young college graduates who planned to pursue a career in medicine, that only one hospital had significant success (but was then experiencing major difficulty) in attracting quality interns and residents to its teaching services, that the physicians (and their patients) had virtually no access to pulmonary function laboratories, gastroendoscopy units, coronary catheterization units or renal dialysis units.

Although each hospital did offer some educational programs (Grand Rounds and conferences), I found that the major formalized resource for the continuing education of physicians was the Rhode Island Medical Society which offered monthly conferences – usually a talk by a visiting lecturer from out-of-state. The major medical publication was the respected *Rhode Island Medical Journal*. And the major driving force, quietly and steadfastly, of the *Journal* – and of the Library – and of continuing education for physicians – and of quality standards of care – was Seebert Goldowsky.

I learned early that he was one of that rare species – a native, actually born in Providence.

His curriculum vitae tells me

today that he was a summa cum laude graduate of the prestigious Classical High School, a summa cum laude graduate of Brown University where he garnered Phi Beta Kappa and Sigma Xi laurels on his way to Harvard Medical School, followed by training in surgery and neurosurgery in Boston, a brief return to the renowned Charles V. Chapin Hospital in Providence as an intern, surgical residency in New York and then the return home to begin his "60 years of service to patients, community and colleagues" as "the ideal of a physician dedicated to a life of learning and service" – accolades finally granted to him in the 1989 Charles H. Hill Award of the Rhode Island Medical Society.

My personal judgments of Seebert have been fashioned by a series of experiences and images beginning with some of his editorials which stimulated and educated, provoked and persuaded. To refresh myself for this essay, I revisited the editorial columns of the *Rhode Island Medical Journal* during my early Providence years (1963, 1964, 1965) and I would recommend a similar intellectual feast for anyone interested in the kaleidoscope of the clinical, scientific, social, economic and philosophical evolution of the medical profession during the explosively

Milton W. Hamolsky, MD, is Chief Administrator, Board of Medical Licensure and Discipline, and Professor of Medical Science Emeritus, Brown University, Providence, Rhode Island.

eventful years of the 1960s and 1970s.

What an astonishing range and breadth of issues and topics – presented either in a brief, spare but impelling abstract or a longer, scholarly, trenchant and balanced exposition of the many facets of a complex issue – objectively, forcefully, without rancor and almost invariably in disarmingly simple, clear and expressive prose.

A mere listing of even the major categories he illuminated during 1963 exceeds my allotted space; 1) the science of medicine – the thymus, treatment(s) of baldness, lipids and arteriosclerosis (one of the earliest, wise, and balanced evaluations I have found), autoimmune disease (the fad vs. the realities), gastric acidity and vagus resection, the progressive unraveling of the scientific facts of mental illness; 2) clinical aspects of medicine – his was one of the earliest, persistent and effective voices concerning the adverse effects of tobacco, then water safety, treatment of shock, measles vaccine, tuberculosis; 3) social, political, economic issues – graduate medical education (the most insightful and informative series of editorials on this evolving problem in the 60s and 70s), the evolution of the Blues and the physicians' role in Blue Shield, medical quackery (relentlessly powerful exposés), nursing homes (forceful, revealing, positively supportive), chronicle of the Brown Program in Medical Education and its impacts (positive and negative) on the community, on affiliated hospitals and physicians – both "town" and "gown" with

balanced and perceptive wisdom; then seat belts, the pros and cons of the computer in medicine, early and cautioning wisdom about the push for quality control and utilization review. Several examples, in hindsight, attest to his visionary and prophetic wisdom.

Interspersed throughout his offerings were the scholarly teachings – by example – of the people and events of the history of medicine. And, permeating so much of his writing, an irrepressible and delightful sense of humor – In "The Weaker Sex" – his discovery that "women live longer than men because they don't marry women" and his early "faint-hearted voice amid the clamorous cacophony of physical fitness and the 50 mile hikes."

There is the image of Seebert, in a staff-meeting of the Rhode Island Hospital (not his major locus of influence) single-handedly initiating and carrying forward a proposal against in-hospital smoking, in any compromised fashion, and patiently, persistently and effectively rebutting each counter-proposal. He did not "win" that day but he started and advanced the inevitable. And, as his curriculum vitae will also repeatedly attest, he put his action where his mouth was, serving as both delegate to, and then chairman of, the Rhode Island Interagency Council on Smoking.

There is the image of Seebert, during a meeting of the House of Delegates of the Medical Society when a group of delegates challenged the priority of the Society's participation in Graduate Medical Education in the face of other impelling issues. Seebert was not alone

but he was a leader of a small group which successfully established the primacy of the obligation of the Medical Society to the continuing education of all physicians in the state.

And his modulated, soft but steel-like voice became the symbol and strength of the library of the Medical Society. Ever vigilant, he thwarted any negative verbalizations or proposals, and introduced, supported vigorously, and usually carried forward all positive growth and developments. His was the first and strongest voice to explore the mutual advantages of merging the libraries of the Medical Society and the Brown Medical School but with the dogged persistence of extracting the most favorable arrangements for both sides.

And there is the image of the physician leader, with the courage of an inner security, at the forefront of major socio-political developments, member of the Board of Directors of the Blue Shield 1958-1962, Medical Advisor to the Rhode Island Blues, 1968-1972, followed by the richly-deserved elevation to the Medical Directorship of the Blues for 10 years, consultant to the Rhode Island Department of Health in Facilities Regulation and Utilization Review. We are all fortunate that there has been a physician with his courage, wisdom, balance, and effectiveness, willing to lead, to bear the brunt, to persevere, to effect significant advances.

And there is the image of the historian scholar. I was first impressed by some of his essays in the *Journal of the Rhode Island Jewish Historical Association*. His writings

became part of my fabric – a rare power, indeed. And I take satisfaction from the recognition that has finally been granted him upon the births of his two major "offsprings" 1) "Yankee Surgeon: The Life and Times of Usher Parsons (1788-1868)", the product of a 30-year gestation, already hailed as one of the major classics of medical biography; and 2) his most recent magnum opus, "A Century and a Quarter of Spiritual Leadership, The Story of Temple Beth-El", the product of a decade of painstaking research that could have been accomplished only by Seebert.

And there is the image of Bonnie, Seebert's wife. Although only Seebert and Bonnie can know the true meanings of their relationship, I cannot envision Seebert without Bonnie, or vice-versa.

Another image of Seebert emerges from even a cursory review of his curriculum vitae, recognition by each of his constituencies of his leadership qualities. As surgeon for 37 years, he rose to serve as President of the Staff, and Chief of Surgery at The Miriam Hospital, President of the Providence Surgical Society, President of the Council of New England State Medical Societies and consultant to the Department of Health, from member of the Board to Medical Director of the Rhode Island Blue Cross and Blue Shield, from writer to Editor-in-Chief of the *Rhode Island Medical Journal* for 29 years and member of National Board of Directors of the State Medical Journal Advertising Bureau, from member of the House of Delegates of the Rhode Island Medical Society to Delegate

from Rhode Island to the American Medical Association, from delegate to the Rhode Island Interagency Council on Smoking to its Chairman and then remaining as active delegate after his term as Chairman, from writer of Jewish history to Editor of the *Rhode Island Jewish Historical Notes* for 18 years, President of the League of Rhode Island Historical Societies and President of the Society of Friends of Touro Synagogue, National Historic Shrine, Inc.

Thus we have Seebert Goldowsky, MD – medical statesman, acknowledged leader in each of his undertakings, scholar, historian, bibliophile, medical politician in the most noble aspects of that phrase, the Dean of Rhode Island Jewish history. And – as

Seebert softly pointed out to friends in an audience gathered recently in his honor, "I made a modestly reasonable living as a surgeon, too."

I can conceive of only one individual who could properly write the biography of Seebert Goldowsky and the true measure of his contributions to Rhode Island. But, of course, he will not do so.

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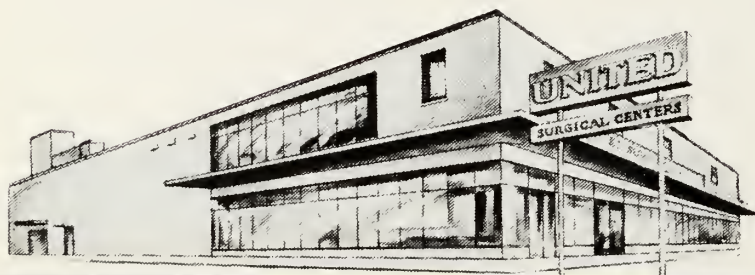
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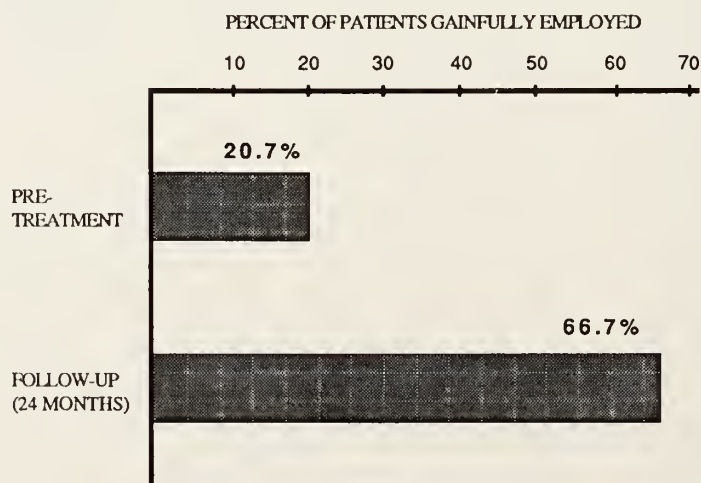
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Recollections of Earlier Days

Jesse P. Eddy, III, MD

As I look back upon my long practice of medicine and surgery in Rhode Island, it is natural for me to think of it in a chronological manner.

The time was July, 1934, and I had just completed my straight surgical internship on the second surgical division of Bellevue Hospital (Cornell), New York City, and had elected to come to Providence and complete my training with Dr Arthur T. Jones, former President of the Rhode Island Medical Society, past Vice-President of the New England Surgical Society, and a top-notch surgeon of his day in Rhode Island and New England. The long five year, plus or minus, residency hospital training days of our present era were just beginning. The leading hospitals in the country were offering two year straight surgical internships, one year surgical residencies, as well as the widely used proctorship training.

Drs Lucius Kingman, E.B. Smith, Arthur T. Jones, Hussey, John W. Keefe, Eliot Shaw and William P. Davis were among the most revered in their communities in those days, and the most successful employed

their own chauffeurs! When I trained with Dr Jones he paid me \$200.00 a month and never before had he paid more than \$100.00, so you can see what nepotism does, even in our glorious medical fraternity! Through friendship with Dr Eliot Shaw and Dr Nat Gifford (he delivered me at home on Broad Street many years ago), I was appointed to the surgical outpatient staff of Rhode Island Hospital, and the urological staff of the Pawtucket Memorial Hospital a month or two later, and hence started my practice.

In those days the country was in a deep economic recession, but illness does not wait upon circumstances, so there was still much to be done. I was not permitted to operate in Rhode Island Hospital because I had not trained there or been appointed to the anesthesia staff, which was common with surgically inclined interns. However, I could operate in the Jane Brown and take my patients there. It was the private pavilion of Rhode Island Hospital (as today). At that stage it did not make much difference as I had no patients anyway! I assisted Dr Jones, but he was not on the staff at Rhode Island Hospital (even though he had his early training there). He had joined Dr Keefe (the only surgeon from Rhode Island whose picture hangs in the private collection of the Mayo brothers at the Clinic in

Rochester, Minnesota).

Dr Adolph Eckstein was in charge of the surgical outpatient department when I was there, but he was so busy with Dr Kingman (whose assistant he was) and with his own practice that I never saw him there. Such men as Dr Joseph Johnson, Dr Melvin, Dr Cox, Dr Stanley Davies and Dr Arthur Hardy (the latter became chief surgeon at Kent County Memorial Hospital) were then on the out-patient department staff.

It was my extreme good fortune, through happenstance, to strike up one of the finest friendships of my life with Dr Stanley Davies (subsequently to become ObGyn chief at the Kent County Memorial Hospital). Stan had the sweetest disposition and was usually on the listening end of any conversation. He was breaking all records for speed between Kent County and the Providence Lying-in Hospital where he was delivering some 400 babies a year! He assisted me in the first subtotal gastrectomy for duodenal ulcer I performed in Rhode Island. In those days, gastroenterostomy was the favored surgical operation.

The patient was a young man of 22 or 23 who had suffered from ulcer disease since his early teens. I had met this individual by accident around 5:30 PM on the sidewalk outside my office door on my way home to

Jesse P. Eddy, III, MD, is a retired physician and surgeon formerly in practice in Pawtucket, Rhode Island.

supper. He asked me if I was Dr Eddy. When I responded, he then asked me if I would give him a letter of recommendation to the Mayo Clinic. I was dumbfounded and asked him who had made that suggestion. He replied that my brother-in-law was a friend and told him I would do so. I inquired if he had a physician, and he told me that Dr Walter Gordon was his physician. I then told him that if Dr Gordon would communicate with me, I would respond to any requests (sidewalk consultation). I sent a letter to Dr Charles Mayo (son of the original Mayo brother) as requested of me by Dr Gordon, and the young man was on his way. I never expected to see the patient again; in fact, he had never been in my office as our contacts had been solely on the sidewalk or by telephone. Hence, you can imagine my wonderment and surprise when I received a big envelope from the Mayo Clinic with X-rays, lab work, and consultation report, advising me to operate upon him if one or more treatments by medical therapy did not succeed. Fortunately, his surgery was a success.

Early Blood Transfusion

I discovered early on that an opportunity existed in our community in the field of blood transfusion, my first love. In the year 1933, 12 blood transfusions had been performed at Rhode Island Hospital and 3 at Pawtucket Memorial Hospital, each being the largest number of transfusions ever performed at either institution in a given year. Through the influence of my father-in-law, Dr Jones, I was made transfusionist at Pawtucket Memorial Hospital

and conceived of the idea of enlisting the voluntary services of the police and firemen of that community to sell their blood at \$40.00 a pint as needed and when voluntary donors were not available. The first year we did 25 transfusions, the next year 50, the next 75, and all this led to the establishment of the first blood bank in Rhode Island at Pawtucket Memorial in 1939. In the fall of that year Dr Anthony Migliaccio, Sr, and I were inducted into the American College of Surgeons at the Annual Clinical Congress in Philadelphia, and the chief subject of the meeting was blood banking in transfusion therapy! Both Dr Migliaccio and I were enthused about this prospect for our state and returned home with the fixed purpose of setting up blood banks in at least two hospitals in Rhode Island; Pawtucket Memorial and Rhode Island Hospital. Dr Irving Beck had just located in Rhode Island in 1939 and at that time spoke with Dr Clark, then Pathologist-in-Chief at the Rhode Island Hospital, about the possibility of starting up a blood bank there. Dr Migliaccio made his own enthusiastic pitch, but the mills of the gods grind slowly and nothing happened for another two years at Rhode Island Hospital. In the meantime Pawtucket Memorial Hospital added Drs Orland Smith and Frederick Webster to the transfusionist staff. We began collecting and preserving blood and making plasma, all with no difficulty because the climate was right! This, of course, knocked out the transfusion business but represented a substantial step forward for Pawtucket

Memorial Hospital and its ability to serve the sick. In the year 1989, Rhode Island Hospital contributed 17,702 red blood cell components to patients in need of transfusion and Pawtucket Memorial Hospital contributed 4,563. In addition, both hospitals provided platelet concentrates and fresh frozen plasma as indicated and prescribed. The old fashioned whole blood transfusion was a thing of the past, except in special instances.

Some Experiences with Sympathetic Nerve Surgery

Dr Frederick V. Hussey and Dr Arthur T. Jones were surgeons-in-chief for six months each at Pawtucket Memorial Hospital and both very good friends of mine. Dr Hussey advised me to interest myself in thoracic surgery and made arrangements for me to be welcomed at the thoracic clinic of the Massachusetts General Hospital and also in the operating room when operations were performed. Hence, I found myself going to Boston once a week to the thoracic clinic meetings and occasionally to the operating room for specific surgery. In one instance, after an operation was cancelled at the last minute, I was invited to make rounds with the vascular group that was doing its weekly stint at the time. Reginald Smithwick, Leland McKittrick and Hannibal Hamlin were some of the others in this group that met on the top floor of the White Building and went down through the floors consulting on the patients that had been put out on the porches for examination. It was a most stimulating experience, and I felt quite

ignorant and behind the times. It was strange for me to see distinguished men displaying such enthusiasm over simple leg ulcers, Burger's Disease, arterial insufficiency and varicose veins. They spoke frequently of sympathectomy as a treatment for many of these conditions. I didn't know what the word meant, but was determined to find out. I visited the operating room of Dr Linton, then Chief of Peripheral-Vascular Surgery at Massachusetts General, but found it difficult to get the finer details of the operation, lumbar sympathectomy, from the viewing stands that were then available. Dr Linton was very kind to me and invited me to be gowned so that I could move up close on a stand and really see what was going on. Thus I learned the basic technique of lumbar sympathectomy from the hands of a master surgeon.

About this time there was a restructuring of the surgical staff of the state general hospital at Howard, and Dr Shaw, newly appointed Surgeon-in-Chief, asked me if I would take a service. I was delighted with the opportunity and accepted with alacrity. One morning while making early rounds I ran across an old friend, a male patient of 35 whom I had known at Rhode Island Hospital. He had severe Burger's Disease and was bedridden. He could not even walk across the ward. Rhode Island Hospital knew him well with his many admissions and had even purchased a special rocking bed for him in the hope of improving his circulation. He was finally discharged to the state hospital as a hopeless case to spend his last days. This was the sort

of case that the Massachusetts General vascular group was most enthusiastic about and would do a lumbar sympathectomy on, and I elected to do the same. The patient made a good recovery, and in 2 weeks' time I did the other side with equally good results. I subsequently learned that he was discharged in one month, got a job as a dishwasher and supported his family for 5 years before succumbing to the ravages of arteriosclerosis. This, I believe, was the first lumbar sympathectomy for peripheral-vascular disease in Rhode Island.

Dr Reginald Smithwick of Boston was making an international reputation for himself with the operation thoracolumbar sympathectomy and splanchnicectomy, wherein the 5th down through the 9th thoracic ganglia were removed, including the greater, lesser and least splanchnic nerves. The 10th, 11th and 12th thoracic ganglia, along with their respective ganglia, were likewise incised. This procedure was done for hypertension, and Dr Robert Baldrige of Providence was the first to do this in our community.

Humor

Humor is where you find it and true humor is apt to be the best of its kind.

It was early Monday morning in the surgical outpatient department and all the examination rooms were teeming with patients, doctors and nurses. I picked up a card from the wall box and found that Lizzie Tisch had a breast tumor. The nurses were all busy so I opened the door of the room, a

room that was divided by a sheet suspended by a long wire. Patients were in each segment of the divided room. "Mrs Tisch", I called out. The only patient I could see nodded. "Would you kindly arrange yourself for the examination. I'll be back with a nurse in a few minutes." Again, she nodded. When I returned, she hadn't made a move. A bit testily I said. "My dear lady, will you please strip to the waist and sit on the edge of the table. I will be back in a minute to examine you." She looked a bit startled, but again she nodded. I remembered old Professor Ewing, the author of that great medical tome "Neoplastic Diseases", who had given us our lectures on pathology. "The first thing you do, gentlemen, is look at the breasts, observe them carefully, see if they are similar, if they look alike, if they appear normal or abnormal in any manner. The next step is to pick them up gently, sort of weigh them in the partially curved palms of your outstretched hands and then move your fingers thoroughly about so that you pick up any masses or irregularities." Finding nothing with these two steps being thoroughly pursued, I said to the patient, "Where is your trouble, Mrs Tisch?" "I have piles, doctor." She was deaf and had misunderstood her name!

Tubal Blockade—An Experience with Sterility

An attractive Mexican girl, in her early thirties, was sent to my office one day because of a painful Bartholin's cyst. She was married with one child. I operated upon her successfully and didn't see her for a number

of years when she suddenly reappeared in my office unannounced. Her husband had deserted her and she had remarried a big, strapping Irishman who was good to her and her child, but he wanted one of his very own, so she was indeed anxious to oblige. I did general gynecology in my practice in those days, but I had never had any experiences with women who wanted children and were not having any luck. I decided to examine her to see if I could determine a cause. Her general physical examination was normal so I sent her to Dr Emanuel Benjamin for a hysterosalpingogram. His findings showed blocked tubes. When I explained her situation and options, she elected surgery, in spite of the fact that I told her there was no guarantee and the numerous surgical procedures available were not very successful. She was adamant and I agreed to make the attempt. After researching the various types of operations that were recommended, I decided on the French cuff procedure if it was feasible. On the night before the surgery I talked with one of the leading gynecologists in the area; a close, good friend who finally told me I had no business doing the operation, that it was a tough operation frequently apt to be unsuccessful.

I developed a modification of the procedure whereby the tubes were injected with sterile methylene blue using hysterosalpingogram technic and leaving the instrument in place under pressure so that when I opened the abdomen the tubes would stand out. This was done. Once inside the tubes, each stood out like the

tower on the Empire State Building. There was no leaking, and when the nurse released the instrument from below, the tubes collapsed. I then had no more to do than cut off the ends of the tubes and turn them back like a French cuff and stitch them into place, peritoneum to peritoneum. The patient did well postoperatively. Two or three years later I was walking down the hospital corridor when a lady approached me. "Do you remember the patient you operated on for sterility a year or two ago?" I said yes. "Well", she said, "She has just had twins!!" You can imagine my delight. She had another baby after that and came to me to have her tubes ligated!

The First Intracardiac Surgery in Rhode Island—Mitral Commissurotomy

My memory does not serve me as well as it should for a small case report on the above subject, but I shall do my best to explain the circumstances.

The general subject of surgery within the heart had been thought of for years with cases done in 1900, 1910, 1920 and, I think 1930. None of these cases were successful and, therefore, not much talked or written about, and it remained for Dr Charles Bailey of Philadelphia and the Hahnemann Hospital to undertake the world's first successful case in 1947.

I had become a close friend of Dr John C. Jones, chief thoracic surgeon at Good Samaritan Hospital, Los Angeles Children's Hospital and Los Angeles County General Hospital. He encouraged me in

my interest in cardiac surgery and urged me to visit Dr Bailey, whom he himself had visited.

I studied the literature on mitral stenosis, assembled the instruments and witnessed several operations. Finally, much to my good fortune, a case of mitral stenosis was referred to me by Dr W. Kiernan Hennessey of Pawtucket. This was a typical case of a patient with a history of rheumatic fever as a child. I referred him to Dr Henry C. Weyler, a well-known cardiologist. The patient was thoroughly worked up. Dr Weyler noted that he had auricular fibrillation for the past 5-6 years and in December, 1949, suffered a cerebral embolism, "probably from his heart". At any event, Dr Lawrence Miscall came down from New York to supervise the procedure. He chose not to scrub, but was there if needed and gave invaluable advice and guidance. Dr Edward Damarjian, anesthetist, ran a tight ship from his end of the table. It turned out to be a highly successful performance. The patient was transfused with 2 units of blood throughout the procedure. The patient made an uneventful recovery and was discharged from the hospital on the 13th postoperative day. He was next admitted to the hospital some 21 years later with acute congestive failure, running a blood pressure of 230/110, taking Lanoxin 25 mg daily since 1951 and Lasix 40 mg daily as well. He passed away some two years later from the ravages of hypertensive arteriosclerosis and rheumatic heart disease after a reasonably long life. This was the first intracardiac heart case, conducted in Rhode Island in 1951.



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Contraindications: VASOTEC* (Enalapril Maleate, MSD) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Warnings: Angioedema. Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and appropriate therapy and monitoring should be provided until complete and sustained resolution of signs and symptoms has occurred. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL) and/or measures necessary to ensure a patent airway, should be promptly provided.** (See ADVERSE REACTIONS.)

Hypotension. Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Patients with heart failure given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed, caution should be observed when initiating therapy (See DOSAGE AND ADMINISTRATION). Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in patients with heart failure), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, Drug Interactions and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident.

In excessive hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis. Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Fetal/Neonatal Morbidity and Mortality. ACE inhibitors, including VASOTEC, can cause fetal and neonatal morbidity and mortality when administered to pregnant women.

Enalapril crosses the human placenta. When ACE inhibitors have been used during the second and third trimesters of pregnancy, there have been reports of hypotension, renal failure, skull hypoplasia, and/or death in the newborn. Oligohydramnios has also been reported, presumably representing decreased renal function in the fetus; limb contractures, craniofacial deformities, hypoplastic lung development and intrauterine growth retardation have been reported in association with oligohydramnios. Patients who do require ACE inhibitors during the second and third trimesters of pregnancy should be apprised of the potential hazards to the fetus, and frequent ultrasound examinations should be performed to look for oligohydramnios. If oligohydramnios is observed, VASOTEC should be discontinued unless it is considered life-saving for the mother.

Other potential risks to the fetus/neonate exposed to ACE inhibitors include: intrauterine growth retardation; prematurity; patent ductus arteriosus; fetal death has also been reported. It is not clear, however, whether these reported events are related to ACE inhibition or to the underlying maternal disease. It is not known whether exposure limited to the first trimester can adversely affect fetal outcome.

Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion.

Enalapril has been removed from the neonatal circulation by peritoneal dialysis and theoretically may be removed by exchange transfusion, although there is no experience with the latter procedure.

There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril, but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day but not at 30 mg/kg/day (50 times the maximum human dose).

If VASOTEC is used during pregnancy or if the patient becomes pregnant while taking VASOTEC, the patient should be apprised of the potential hazards to the fetus.

Precautions: General: Impaired Renal Function. As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dose reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hyperkalemia. Elevated serum potassium (> 5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See Drug Interactions.)

Cough. Cough has been reported with the use of ACE inhibitors. Characteristically the cough is nonproductive, persistent and resolves after discontinuation of therapy. ACE-inhibitor-induced cough should be considered as part of the differential diagnosis of cough.

Surgery/Anesthesia. In patients undergoing major surgery or during anesthesia with agents that produce hypotension enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients: Angioedema. Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension. Patients should be cautioned to report lightheadedness, especially during the first few days of therapy. If

actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia. Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia. Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions: Hypotension: Patients on Diuretic Therapy. Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

Agents Causing Renin Release. The antihypertensive effect of VASOTEC* (Enalapril Maleate, MSD) is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents. VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methylglucosides, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium. VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium. Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium.

Pregnancy: Pregnancy Category D. See WARNINGS, Fetal/Neonatal Morbidity and Mortality.

Nursing Mothers. Enalapril and enalaprilat are detected in human milk in trace amounts. Caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use. Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

HYPERTENSION. The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

HEART FAILURE. The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

Cardiovascular: Cardiac arrest, myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, Hypotension); pulmonary embolism and infarction, pulmonary edema, rhythm disturbances including atrial tachycardia and bradycardia, atrial fibrillation, palpitation.

Digestive: Ileus, pancreatitis, hepatitis (hepatocellular [proven on rechallenge] or cholestatic jaundice), melena, anorexia, dyspepsia, constipation, glossitis, stomatitis, dry mouth.

Musculoskeletal: Muscle cramps.

Nervous/Psychiatric: Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Respiratory: Bronchospasm, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection.

Skin: Exfoliative dermatitis, toxic epidermal necrolysis, Stevens-Johnson syndrome, herpes zoster, erythema multiforme, urticaria, pruritus, alopecia, flushing, diaphoresis.

Special Senses: Blurred vision, taste alteration, anosmia, tinnitus, conjunctivitis, dry eyes, tearing.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION), impotence.

A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgia/arthritis, myalgia, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash, and other dermatologic manifestations.

Angioedema. Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension. In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Fetal/Neonatal Morbidity and Mortality. In infants exposed *in utero* to ACE inhibitors the following adverse experiences have been reported: Fetal and neonatal death, renal failure, hypoplastic lung development, hypotension, hyperkalemia, skull hypoplasia, limb contractures, craniofacial deformities, intrauterine growth retardation, prematurity and patent ductus arteriosus. (See WARNINGS, Fetal/Neonatal Morbidity and Mortality.)

Clinical Laboratory Test Findings: Serum Electrolytes. Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen. In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit. Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g% and 1.0 vol%, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Other (Causal Relationship Unknown). In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported. A few cases of hemolysis have been reported in patients with G6PD deficiency.

Liver Function Tests. Elevations of liver enzymes and/or serum bilirubin have occurred.

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The Ramgarh Experience

Thomas Perry, Jr, MD

During World War II the Rhode Island Hospital organized and sent in to service a group of doctors and nurses to staff the Army's 48th Evacuation Hospital. These professionals plus a few more joined an already partially trained team of enlisted men at Camp Devens in August, 1942.

Seven months later the 48th found itself unemployed in the jungles of Assam Province in North East India along with units from the Pennsylvania Hospital and the Los Angeles County Hospital. In typical "hurry up and wait" fashion we had been rushed there to back up an offensive to open a supply line through northern Burma to China's back door. It was to take well over a year for Chinese troops to be trained and assembled and a road built by American engineers to start that offensive.

In the past, articles have appeared in this *Journal* about the 48th Evac, but nothing has been written concerning "the Ramgarh experience". After a couple of months of sitting, mostly in the rain, the Hospital was temporarily broken into several small groups and one

large one, consisting of about half the outfit, for special assignments.

The members of the larger group have always had a bit of a guilt complex for we were to live in relative comfort compared to most of our colleagues, but we did have a fascinating year from both medical and sociologic standpoints. Eighteen doctors, two medical administrators, about forty nurses, and a large body of technicians, cooks, and other personnel made the trip to Ramgarh, a tiny isolated village in Bihar Province 150 crow flight miles northwest of Calcutta. Here Chinese troops were being trained for the coming campaign.

To get there we retraced our steps to Calcutta first by very narrow gauge railway, then by less narrow gauge to the ferry which took us down a section of the mighty Brahmaputra River in spring flood. On occasion we would see enormous fresh water porpoises surface in the opaque brown water and wonder how they could see to find food in the murk. Three more train changes brought us to Ramgarh. We had traversed jungle, open farms, rice paddies, and teeming cities in a completely foreign land. This in itself was an adventure, but it was not greatly appreciated during the seven day journey, much of it spent on railroad

sidings, in crowded trains with temperatures frequently over 100 degrees F.

On arrival we found ourselves in somewhat rolling terrain with distant, high hills. Here the British had constructed a facility to house Italian prisoners of war from North Africa. More recently the surrounding region had been taken over to rehabilitate and retrain the remnants of several Chinese divisions that had escaped over jungle mountain trails into India when Burma was overrun by the Japanese. The old prison compound had been converted into a hospital which was staffed by a motley crew that at one time included Gordon Seagraves, the famous Burma Surgeon, and an American surgeon who is said to have fallen in disfavor with the Theater Surgeon for keeping his dog tied to the operating table during his procedures. Hence our arrival on the scene.

The idea was to fly more Chinese "over the hump" to build two or more serviceable divisions. Our part in the affair was housed in single story, tile-roofed, brick and plaster, more or less open structures. These contained wards for about twenty patients each. Our own living quarters were of similar construction, consisting of a row of eight or so rooms opening front and back. Two doctors to a room was standard. Each

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pair would employ a native bearer for thirty cents a day to keep the place clean, fetch water, lay out our toothbrushes with tooth paste on them each morning, and similar essential functions. The few local British were outraged that the Americans were doubling the usual wages.

To operate the hospital there were fourteen doctors with Rhode Island Hospital connections. Internists were Robert Murphy, William J.H. Fischer, Frank B. Cutts, Palmer Congdon, John A. Dillon, D. Richard Baronian, and Herman (Dick) Lawson, who was chief of medicine until he was put in charge of the entire hospital. This came about when the regular army officer assigned to the position was kicked upstairs. Surgeons were J. Murray Beardsley, William Teahan, Gerald Melvin, J. Merrill Gibson, and Thomas Perry, Jr. Dr Beardsley acted as chief of surgery except when he was outranked by Kwan Heen Ho from St. Louis who was with us for a few months. Orthopedists were Arthur Martin and Vincent Zecchino. Edward Damarjian was anesthetist with Perry pressed into service when needed. Edward Squire was the dentist. In addition Edward Meister of Lowell, MA was the adjutant and Solomon Brav, of Philadelphia, the ophthalmologist. Medical administrative officers were William W. White, later a top officer in the Rhode Island Hospital Trust Co, and Richard Chauvet.

Among the nurses were several who are still living in Rhode Island; Rachel Andrews, Ann MacIntosh, Janet Easdon, Alice Leach Buffington, Mary McDonald McDonnell, and Kay



The author and his patients

Hodnett Stock. Kathleen Herbert, now Mrs Palmer Congdon, joined the unit in Ramgarh.

Under the circumstances there was a minimum of surgery so the younger surgeons assumed duties on medical wards. This was of great help particularly when a train-load of six hundred new Chinese recruits arrived, as happened periodically. These were boys and young men who had been Shanghaied out of western China. Their physical condition was deplorable. If they had been able-bodied enough they would have escaped to the hills in the first place. The weak and starving let themselves be caught. After being flown to Assam, they would spend a couple of weeks on the long train ride to Ramgarh without mosquito nets which were always essential.

When they reached us, there would be lifeless bodies on the train and a few unconscious. Up to one-third would be hospitalized within twenty-four hours. About one-quarter had

clinical beri-beri with edema. Many were febrile to 104 degrees F or more, mostly with *Plasmodium vivax* and *Plasmodium falciparum* malaria and relapsing fever. Blood smears usually, but not always, provided the diagnosis in a hurry. In the worst cases of relapsing fever the spirochetes in the blood smear would be so thick as to resemble loose steel wool. One dose of neoarsphenamine cured these people almost magically. It was John Dillon who figured out that the rare post-treatment death was due to anaphylactic shock from the protein released by the dead spirochetes. Thereafter the sickest patients were treated initially with low doses of the arsenical.

Malaria was treated with quinine until we finally got atabrine. Which recalls the British liaison officer who showed up with malaria. Instead of ten grains of quinine three times daily, the ward attendant started him on ten pills (5 grains each) per dose. After six pills of the second dose the



Hospital Administration Building

savvy Britisher demurred. He was nearly totally deaf for two anxious weeks, but needed no further treatment.

At one point we began to lose falciparum malaria patients who were under adequate treatment. This problem was solved when it was found the patients were hiding their medication to sell later on the black market.

Many of the new recruits had far advanced tuberculosis and this was before the days of antibiotic treatment of the disease. Mortality was high because the only treatment was rest and isolation.

Probably every Chinese had intestinal parasite ranging from usually harmless *Ascaris lumbricoides* to *Entamoeba histolytica*. One laboratory technician twice marched himself down to the wards and pinned the order of the purple stool on mystified Chinese whose stool specimens had yielded five different parasites.

Chronic severe hypochromic anemia was common among the

heavily parasitized especially those with hookworm. One gentleman who came to be known as the bloodless Chinaman wavered into the hospital with a hemoglobin of 1.6 gm per 100 ml.

It was truly marvelous to see these woebegone recruits four months later, fat and jolly, after good food and care, marching down the road shouting out the cadence as they went.

Everyday medical practice revealed several rarities. There were cases of small pox, two I believe, and one of generalized vaccinia from vaccinating a patient who had scabies. Frank Cutts diagnosed a case of lung fluke (*Paragonamus westermanni*) and Dick Lawson, who held Frank in high esteem, frequently referred to him as *Paragonamus Cutts* thereafter. Our only case of kala azar was in an Indian native and diagnosed after a considerable delay through a bone marrow smear taken when looking for malaria parasites. This method we found safer than, and just as

effective as, splenic puncture when plasmodia could not be found in the peripheral blood smear.

Heat stroke was a problem. The Chinese officers treated their soldiers unmercifully with no let up in drills in the great heat. Those heat victims who reached us were usually comatose or nearly so and rarely survived in spite of being packed in ice. When they died, their buddies usually ran off with the ice.

The Chinese Army was paid by giving all the wages for a division to its commanding general. The amount he received for distribution was based on the number of troops under his command. Therefore, when his outfit moved out, he would want to get back all his hospitalized troops. Some would leave on stretchers. Two of Dr Beardsley's rope grafts awaiting the final stage disappeared in this fashion.

The weather had other effects than heat stroke. It could be unbelievably hot. At the end of the dry winter season on about April 1st the temperature would reach 100 degrees F. For the next two months the daily maximum inched up to about 122 degrees with the nights at 95 degrees F. It was so dry that though we drank quantities of water we would not sweat a drop, but at the end of the day could scrape a salty grime from our faces.

Then came the rains with daily highs of only 100-110 degrees F. Skin rashes, diarrhea, and malaria all flourished, but just when it all seemed unbearable in October the most glorious weather anywhere, ever, set in; clear skies for five months with warm days and

two blankets at night.

Anesthesia was a problem in the dry heat. We had no anesthesia machines and open-drop ether at 110 degrees F was almost impossible, the ether vaporized so quickly. Fortunately we could get chloroform from the British.

The only spinal anesthetic, also of British origin, was a product called percaine which was hypobaric and came in 20 ml ampules. The anesthetists had to adjust to the large volume and also to tipping the patient's head up instead of down to achieve the proper level. There were some long, anxious hours on occasion when, during the learning process, too high a level was reached, for the anesthesia lasted three hours.

Surgery was routine for the most part, but there were exceptions. The novice Chinese truck drivers gloried in high speeds. This was particularly troublesome when they capsize a vehicle loaded with troops. The trick was to find the ruptured spleen as soon as possible among the dozen or more casualties. There usually was one for up to 50% of the troops had palpable malarial spleens.

After just such an accident one poor soul came in with a three inch tree limb through his liver. It was thought it just couldn't be left there even in the absence of a blood bank and the removal under anesthesia would at least be the most merciful course. It was and quickly.

Diphtheritic leg ulcers were not uncommon, though we did not see the disease in its usual form. It was important to clear the ulcers up quickly as they

carried a high incidence of diphtheritic myocarditis. After experimentation the ulcers were found to respond best to complete excision and filling the resultant defect with pinch grafts.

At this point there is no way to research how many patients we treated. There was no place to send the records on the Chinese so they were destroyed. In general we had enough work to keep us busy and were rarely overworked.

Our own health remained pretty good. Frank Cutts lost his appendix and Murray Beardsley had prolonged and severe infectious hepatitis. Almost everyone took bismuth and paregoric intermittently for diarrhea. It wasn't till years later that we learned that *Giardia lamblia* is a pathogen, not a saprophyte, which may explain some of our symptoms. It is my own opinion that our giardiasis disappeared when we finally got atabrine for malaria prophylaxis.

Relaxation among the doctors of the 48th took various forms. Except in the severest heat and heavy rain there was a rousing volleyball game late

every afternoon. There was tennis, for a few, a short jeep ride away. Bridge games, always with the same partner, were a favorite evening entertainment. On a few holidays there were dances with the nurses.

We did get away from the reservation once in a while. Some took a day trip to visit the source of our dairy supplies, a herd of 900 enormous water buffalo operated by the British. Others visited a leprosarium where about 800 patients were being treated with chaulmoogra oil with noteworthy success. The nearby village of several hundred arrested cases and their families was by far the cleanest and neatest we saw anywhere.

Occasional overnight hunting trips were popular with the enlisted men who had to have an officer with them. The method of pursuit in a jeep armed with a jacklight and repeating rifles is almost too shameful to admit. The game, nevertheless, was remarkably immune to these attacks. Elk-sized deer known as Sambar ran away untouched even at close range. Once I had a good,



Chinese Patients at Ramgarh



Dr Palmer Congdon doing a chest tap

highest mountain, looming in the foreground with Mt Everest, clear as a bell, eighty miles away in the left background. To some of us this was the biggest thrill of our overseas experience.

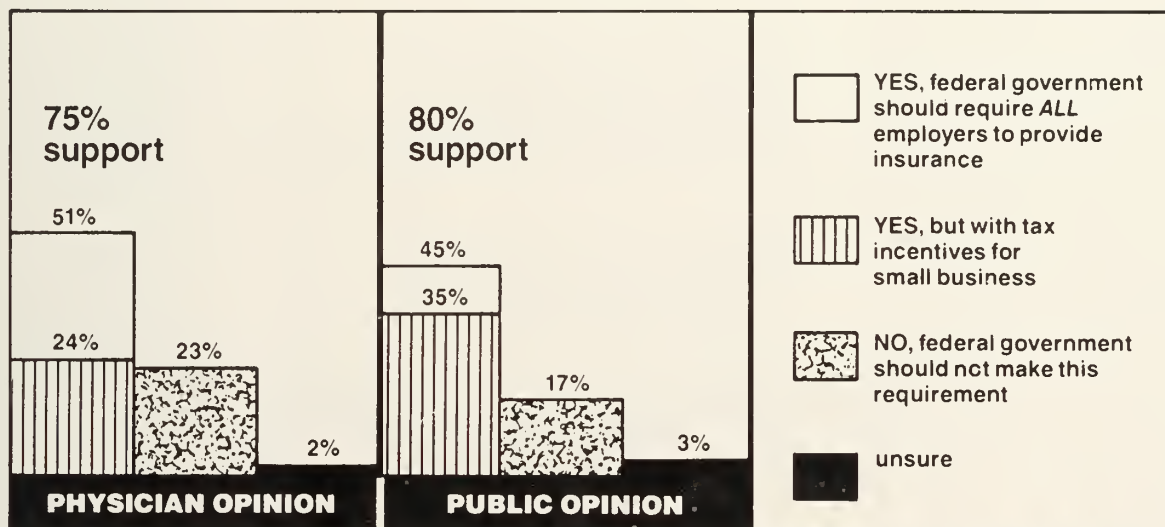
In late May of 1944, after a year of separation, the 48th Evacuation Hospital was reassembled to provide backup in Assam for the long awaited push into Burma. Here our 750 bed hospital was host to over 2,000 patients at a time. Later we set up business in Myitkyina in northern Burma and from there rotated back to the United States in small groups in the spring of 1945.

though distant, look at a tiger bounding away. The nearest rajah entertained several of the top ranking officers on elephant-mounted hunts complete with native beaters.

Most people had a short

leave in Calcutta and many a memorable trip to Darjeeling. From there we took a three day trip afoot or on pony-back to 12,000 feet of altitude. Here we had a gorgeous view of Kinchenjunga, the world's third

Ramgarh has receded into a misty memory. It would be nice to go back sometime, but surely there will never be a year to match the one we spent there.



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Serendipity Lost: A Digressive Account of an Experience in the Investigation of Glucuronic Acid Metabolism in Diabetes Mellitus

Irving A. Beck, MD

Published reports of scientific investigations in the current era usually follow a format prescribed by the International Committee of Medical Journal editors.¹ While desirable from a strictly scientific viewpoint, the format fails to include the peripheral circumstances that led to the genesis of the investigation. Examples include a meeting of minds which may have generated a spark, or from an observation due to chance. Prior to the 20th century, scientific reports were frequently circumstantial and anecdotal. The report often would be narrative in style and include circumstances peripheral to, yet of influence in, the evolution of the investigation. An example of this style is Withering's classic essay on his discovery of the use of digitalis, *An Account of the Foxglove and Some of Its Medical Uses* (1785). In narrative style, Withering refers to the role of the "old woman in Shropshire" and circumstances which currently would be regarded as peripheral, yet led him to introduce the drug "into the more regular mode of prescription."

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Using this as a precedent in this reminiscence, I am reverting to the narrative style, first person singular, with none of the prescribed subheadings, to relate how an investigation really evolved and its subsequent ramifications, or lack of them.

In January, 1954, an article appeared in the journal *Metabolism* with the title, "Serum Glucuronic Acid Levels in Diabetes Mellitus."² The authors were Drs Abraham Saltzman, Wendell T. Caraway and Irving A. Beck. Its conventional format would have been acceptable to the International Committee today.

The first two sentences of the article read as follows: "In a larger study involving the fate of sodium cinnamate as a test substance in the evaluation of liver function³, fasting glucuronic acid levels were determined in normal controls and in various pathologic states. Elevated levels of glucuronic acid were often encountered in patients with diabetes mellitus." This impersonal statement in the passive mode conveys little of the story leading to the project, which I now propose to remedy.

First, about the authors: Saltzman, a recent arrival in Providence, was an internist with a demonstrated flair for scientific investigation and with an impressive list of prior publications. These included such

diverse topics as explaining the anatomical mechanics enabling rodents to squeeze through small holes, the design of an autoclavable dialyzer as an artificial kidney, devising tests of liver function and fluorometric analyses of blood levels of various medications. Concomitant with his medical practice, he was carrying on laboratory investigations as a US Public Health Fellow in collaboration with Dr Caraway at the Rhode Island Hospital on tests of liver function.

Caraway, the hospital biochemist, in addition to his clinical responsibilities, was a brilliant researcher engaged in devising a microchemical method of blood analysis which later became a standard.

I was in private practice, an attending physician at the Rhode Island Hospital, and in charge of its Diabetic Clinic.

The seed of our investigation was planted in 1952 while I was having lunch in the Rhode Island Hospital Doctors' Dining Room. Saltzman sat down next to me, and in the course of our conversation, he called my attention to an observation he had noted in the course of his liver function test studies. He mentioned that in the control group of patients without liver disease, two diabetics with retinopathy and glomerulosclerosis of the Kimmelstiel-Wilson syndrome unexpectedly

had shown very high levels of glucuronic acid. Since glucuronic acid was excreted via the kidneys, my knee jerk response was that the levels were compatible with the renal damage in this syndrome. He had also noted that some other diabetics with normal liver and kidney functions had higher levels than expected. We decided that the cause be explored, particularly since a literature search disclosed that serum glucuronic levels had been done in a small series of diabetics and were found to be normal.⁴ We left the dining room with a tentative schema for a new project. Using a protocol similar to the cinnamic liver function study, normal subjects and a mixed outpatient (from the diabetic clinic)-inpatient group had blood glucuronic acid tests performed under controlled circumstances which included omission of all drugs for the prior 24 hours. Early in the project it appeared that there was indeed some correlation of diabetic severity with elevated glucuronic acid levels. We used as a gauge of severity the method of control of the diabetes, by either diet or insulin. In the latter instance, the amount of insulin taken was regarded as an index of severity.

To summarize our results briefly: elevation of glucuronic acid levels occurred in 56.6% of diabetics, 9.6% of whom had normal glucose levels at the time of the test. On the basis of the reported data on glucuronic acid metabolism we attempted an explanation. Liver glycogen is regarded as the initial source of glucuronic acid, and as a moderate depletion of liver glycogen was known to occur

in diabetes mellitus, degradation of glycogen to glucuronic acid might have occurred to a greater extent. Another hypothesis was that the elevated levels represented increased removal of endogenous metabolites via glucuronide conjugation.

We planned to conduct further studies, particularly in regard to a possible association with renal function, but outside factors prevented this. Dr Saltzman was called into Army Medical Corps, returning in 1955. He did not resume his laboratory investigations but devoted his time to medical practice. Dr Caraway in 1957 moved to Flint, Michigan, where he still resides. His subsequent career has been most productive, making contributions to the kinetics and mechanisms of reactions, serum enzyme assays, ultramicrochemical methods of blood analysis, and drug effects on laboratory tests. He was the President of the American Association of Clinical Chemists, and received honors and awards for his achievements. However, he never resumed any research pertinent to glucuronic acid metabolism.⁵

The question arises, did our truncated project contribute to further investigations relative to glucuronic metabolism? The answer is contained in the following:

In 1961, Winegrad reported in a symposium on "Diabetes and its Complications"⁶ that the synthesis of glucosamine from glucose to glycoprotein implicated in the lesions of diabetic glomerulosclerosis appeared to occur by a pathway independent of the action of insulin. His studies indicated that an

important component of acid polysaccharide, a glucuronic acid, could be synthesized from glucose by a pathway which is non-insulin sensitive. In subsequent papers^{7,8}, he and an associate presented data indicating that glucose utilization by way of the glucuronic acid pathway is increased in diabetes mellitus and might be a factor in vascular lesions. His list of references did not include our paper, nor have I located any mention of it in a scan of the literature.

Several years ago in leafing through the biography of Dr David L. Edsall, the noted and innovative Dean of the Harvard Medical School, by Joseph C. Aub⁹ an item in his list of published papers had caught my eye: "Concerning the Benzoyl Esters of the Urine in Diabetes Mellitus and the Clinical Significance of an Excess of Glycoronic Acid"¹⁰ Up to that point, I had not realized that Dr Edsall (whose deanship included my sojourn at the Harvard Medical School) had been a prolific investigator particularly in the field of metabolism. In preparation for this essay, I reviewed his contribution. Considering that chemical studies of the blood were limited at that time, and that the urine was the body fluid most examined, the existence of insulin unknown, one of the observations reported was prescient. Thus, Edsall quoted Mayer, a German investigator as not having definite evidence for his conclusion that "glycoronic acid is a step in the katabolism of sugar."¹¹ In Edsall's own opinion the excess of glucuronates was actually due to "intoxications." The latter paraphrases one of our

own tentative, probably erroneous, suggestions that the increased glucuronic blood levels might be due to conjugation with metabolites. If indeed, Mayer's evidence was faulty, the elegant studies of Winegrad's 60 odd years later demonstrated that glucose utilization by the glucuronic acid pathway is increased in diabetes mellitus.

The term serendipity was coined by Horace Walpole in 1754, based on a fairy tale "The Three Princes of Serendip" (now Sri Lanka) to mean the faculty of making happy and unexpected discoveries by accident. Its application to scientific discovery was popularized by the eminent Harvard physiologist Walter B. Cannon in his collection of essays "The Way of an Investigator" in the chapter entitled, "Gains from Serendipity".¹² In it he records a number of such historical instances. The concept was not really new. Many of Pasteur's discoveries appear to have been made by chance, but, in the course of a lecture, he said that "chance favors only the prepared mind"¹³, ("only" is frequently omitted from the quotation as used).

In their collection of essays on "Paths of Discovery in the Biomedical Sciences," Swazey and Reeds¹⁴ indicate how complicated the nuances of the term have become. One has been the coinage of modifying terms, eg, "serendipity gained" and "serendipity lost". This stems from an essay in 1954 by two sociologists—Bernard Barber and Renee C. Foy.¹⁵ They noted how two scientists, Lewis Thomas and Aaron Kellner, each independently noted reversible collapse of rabbits'

ears after the injection of the enzyme papain. Thomas followed through on this lead and noticed a quantitative change in the matrix of the cartilage and extended the investigation to include other cartilaginous tissues, as well. He determined that it was reversible with cortisone. The elucidation of this phenomenon Barber and Fox termed "serendipity gained." Actually, the writers were more prescient than they realized for in the last decade papain has been introduced into neurosurgery for the dissolution of extruded vertebral discs and thereby eliminating surgery. This mode of treatment was quite popular for a while, but because of allergic and other complications has now been largely abandoned.

Kellner, preoccupied with other research possibilities, failed to follow through with further research of this particular phenomenon. Hence, his initial observation was regarded by Barber and Fox as "serendipity lost."

This reminiscence is an example of how scientific investigations can be conceived but the attendant circumstances not reportable in today's "just the facts, ma'am" format.

Chance was the major factor initiating our study and in a negative fashion for the failure to follow through with further studies. The end result can be termed "serendipity lost."

* * *

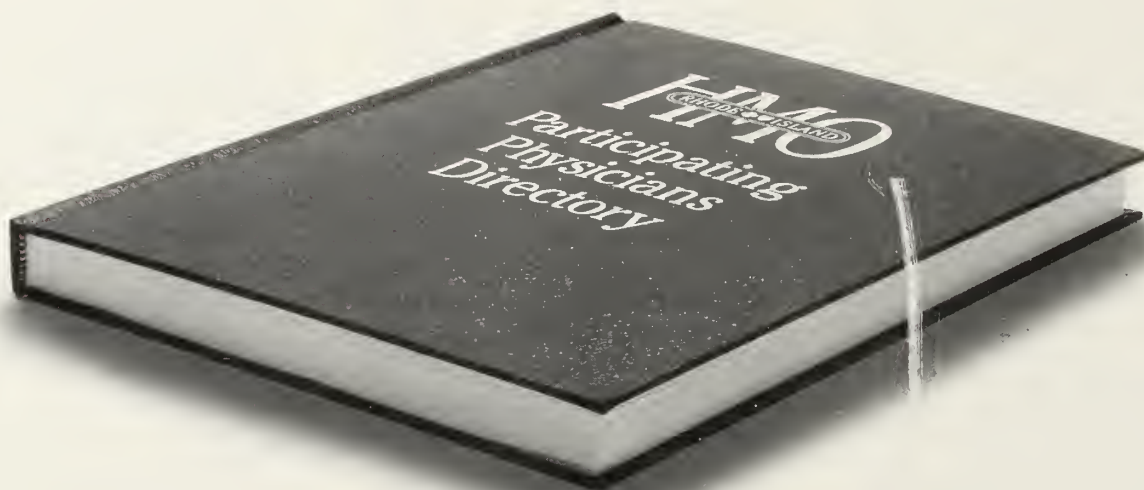
The assistance of Dr Abraham Saltzman, Mrs Grace Varghese and Mr Frank Kellerman is gratefully acknowledged.

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A Medical School Without A Tomorrow

Hugo Taussig, MD

This contribution to the Festschrift honoring Dr Seebert Goldowsky is likely to be a change of pace from the other ones, and is from a different historical perspective. A touch exotic perhaps, but not really alien to a land that—with the exception of the original inhabitants—has risen from the tales that ancestors brought with them from far away places.

The Medical School of the University of Bucharest, the capital of Romania, had a respectable tradition. Among others, Dr Marinescu enjoyed international recognition as a pioneer neurologist. Prof Constantin Parhon, the patriarchal department chief of psychiatry at that University in my time, together with Dr Moses H. Goldstein who taught the physiology of the nervous system at the school on which I am about to report, had published the first widely used handbook of endocrinology in 1909, — in Paris. In more peaceful times up to World War II, the French cultural influence had been easily grafted on the intellec-

tual life of Romania, a Latin country first colonized by ancient Rome. Bucharest was known as "little Paris". French was a second language; anatomy, for instance, was read from the original text of Rouvière.

What did not generally take root, alas, on Romanian soil, after centuries of Greek and Turkish occupation, was French enlightenment and humanism. A fledgling, tentative experience of democracy after World War I was unable to come to grips with the enormous gap between affluence and poverty, with pervasively corroding ethnic conflicts. Consistent with the tradition of centuries, it all was the fault of the Jews.

About two decades before the German theorists, Prof A.C. Cuza had written his treatise on racial inferiority, easily accepted at the universities in the traditionally prevailing prejudicial atmosphere. *Numerus clausus*, a limited quota of admissions, had always been the unwritten, but strictly observed rule.

In the academic year of 1940-1941 it was it. No more Jews were to be admitted to any public schools and Jews were no longer to teach anywhere: *numerus nullus*. So what did they do? They established their own

university. In order to appreciate the enormity of the undertaking, it is necessary to visualize the moment in history, the political climate, the environment of daily life in the wartime town. In the fall of 1940 the Romanian army had joined the German one in the offensive on the Russian front, following a coup d'état by the new fascist regime, the "Iron Guard". In the spring of 1941 a pogrom in the Jewish quarter had cost about 500 lives. Walking in the city was dangerous. Bands of hooligans, predominantly students, roamed the streets to beat up people who looked to them like Jews. Around every corner there could be a military patrol checking identity cards. All Jewish males were subject to "mandatory public works", like grave digging at appropriate occasions, road repairs and snow shoveling during the long, hard winters. Apartment raids and sweeps on the streets, at unpredictable times, made sure that nobody missed the opportunity to serve. The Axis armies advanced relentlessly into the Soviet Union. One did not know if one would be alive next day and there seemed to be no future for a civilized world. There was no tomorrow.

What else, then, was there to do than to go on learning and

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teaching? The atavistic instinct that scholarship was the antidote to obscurantism did not fail us. A variety of small Jewish schools, from kindergarten to high school, sprang up quickly and spontaneously, privately run and sponsored.

And then an initiative began to take shape, the very idea of which defied any hope of success, given the prevailing conditions. It did succeed primarily due to the devotion, courage and tenacity of one man, Prof Marcu Onescu (Fig. 1), a teacher of jurisprudence, a lawyer with a doctorate from Rome and a contagious belief that it had to be done and could be done.

He galvanized a rapidly spreading number of recently dismissed faculty, who began teaching without salary to start with; he contributed money of his own and set about fundraising from an already financially devastated Jewish community. With the tacit support of opponents of the fascist regime within the administration, he obtained the authorization from the Department of Education (subject to constant threats of being withdrawn) for a university to be set up in Bucharest. Because of bureaucratic pettiness it was to be called "College for Jewish Students". (Soon, in everyday parlance, it came to be known as "Onescu College".) But a fullblown university it immediately turned out to be, thanks to the large, available reservoir of distinguished teachers.

Departments were organized for:

1) Technical Sciences, including sections for mathematics, physics and chemistry, architecture, subspecialties of

engineering;

2) The humanities; languages, literature, history, philosophy, psychology, sociology, ethics, among others;

3) Economics, agronomy and business school;

4) Human Biology, last but not least, covering all basic sciences leading to the study of medicine.

The school remained in operation from 1941 to 1944. During these years 1,394 students were registered; a great many of them now scattered all over the world. (I do not have the breakdown as to how many of them went into medicine.) It was located in a sprawling, abandoned mansion, rather dilapidated, with thick brick walls providing the illusion of protection. There was plenty of space for classrooms and offices. The author's then juvenile head can be spotted in the row before last, gravely pondering an examination question (Fig. 2). Laboratory equipment was sparse and precious. Hence the labs were crowded (Fig. 3) and microscopes shared by many (Fig. 4). Anatomical dissection was done on stalls in the former stables (Fig. 5).

To obtain cadavers one had to face a bureaucratic obstacle course—as was the case with practically everything else—and naturally the cadavers had to be strictly Jewish.

These inconveniences were more than counterbalanced by the quality and imaginative variety of the courses offered. There was excitement in the air, denial of and refuge from the surrounding reality. Systematic longrange research was a luxury impossible to consider in these volatile, unpredictable



Fig. 1. Marcu Onescu

circumstances. What mattered was the creativity and the depth of the teaching, the emotional commitment of the teachers that carried along the students' intellect and imagination. The way that Dr Benedict Menkes, just for one instance, brought to life the integration of form and function in the anatomy and physiology of the human body, the beauty of it, has stayed with me indelibly.

As clinical experience for the students and as a much needed community service, an outpatient clinic was set up, with help and equipment from the Red Cross, discreetly called "Polyclinic J" (for Jewish). The patients who flooded it were not expected to pay, nor did the doctors expect to be paid. An amazing amount of service of high quality was being delivered with rudimentary means: infectious diseases (lots of typhoid), rather sophisticated outpatient surgery, oncology treatment such as it was, unlim-



Figure 2. Examination Time

ited house calls, to name a few.

The tide of war had turned by the spring of 1944, my second year of attendance, and the bombs had started to fall. From their bases in Italy, the US Air Force and the Royal Air Force, for about four months, began to make almost daily runs over Bucharest and the nearby oil fields of Ploesti. Panic and paralysis set in for a while, as casualties and destruction were considerable. The planes were greeted with wrenching ambivalence; along with the terror, they brought the hope for change.

Then the infinite capacity of human beings to adapt to adversity showed itself once more. With almost predictable regularity the American bombers came in the morning and the British bombers came at night. Life returned to a sort of routine, punctuated by an odd mixture of fear and excitement. One went back to work, interrupted by the sound of the air raid sirens and the descent into largely ineffective shelters. My

grandmother, impeccably dressed for the occasion, went downstairs reluctantly, after having carefully prepared the mid-day meal: "If we survive, we've got to have something to eat".

Then there were those students also active in the underground resistance. Three of them faced a firing squad, refusing to be blindfolded. This paper is dedicated to their memory.

The College continued to function without missing a beat. Because of the time spent sitting in shelters and of the added ongoing mandatory public work obligation, now including the clearing of rubble, studying was done into the early hours of the morning.

Then there were those students also active in the underground resistance. Three of them faced a firing squad, refusing to be blind-folded. This paper is dedicated to their

memory.

The Jewish physicians, barred by the Medical Society from treating Gentile patients, as well as from holding any official position, were among the first to man civil defense stations and to care for the casualties.

By August the German troops had retreated and the Soviet tanks had rumbled into town: In essence, a jump from the frying pan into the fire. But evidently there were going to be some changes. On 23 August 1944 the government managed to make the switch from the losers of the war to the victors; the country having already practiced the same move at the end of World War I. A period of much more erratic German bombings followed for a while, before things began to settle down.

One change was that the University of Bucharest opened its doors to everyone, this time without any restrictions. All along, the College for Jewish Students had kept meticulous individual records of attendance, performance and examination grades, which made for a smooth and immediate transition to the clinical years of medical studies and for easy access to teaching hospitals and research facilities. It might have been most interesting to tabulate the comparative achievement levels of the students from the official, racially sanitized medical school and those from the improvised Jewish one. There was no doubt in anyone's mind, however, that the latter were extremely well grounded in the basic sciences, mature and responsible before their time, having emerged from this crucible.

In retrospect it was an experience one would not have willingly chosen to make. But looking back on it, one would not have wanted to miss it.

Coda

It is hoped that this story will please Dr Goldowsky, a scholar of the history of medicine and of the Jews. He, of all people, will not be surprised to find yet another example of the unremitting, unconditional love of the book, that has sustained the Jewish people through millennia of persecution; learning

as an obligation and as a thing of joy, regardless of circumstances, however dire they may be. And he might like to add this vignette to his erudite knowledge of the long line of illustrious predecessors whose love of learning expressed itself in the humane art of practicing the science of medicine.

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Fig. 4. Oh, for a free microscope!



Fig. 3. A laboratory



Fig. 5. The anatomy lesson



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One Physician's Mission

Frank J. Lepreau, Jr, MD

I don't know where the "mission" urge came from, but it has always been strong. I just did not know where to begin.

"Why don't you write Larry Mellon?" Clee Rea asked as we were walking back to our car after a Tanglewood concert one August evening in 1959. Our Wellesley wives had arranged the weekend rendezvous – the Reas from Pittsburgh where Clee was a trust officer in the Mellon Bank, and we from Westport and Fall River where I was in the private practice of surgery. It was twenty years later that I learned from Mrs Larimer Mellon of the close professional relationship between them and Cleveland Rea. I wrote. No response. I put it out of my mind.

I then learned that the young general practitioner at Friends Africa Mission near Lake Victoria in Kenya had been there for two years and was looking for relief, so I went. He coached me for a month and then I was alone, the only doctor in a 100-bed hospital with a

large outpatient department, surrounded by a multitude of strange people with strange diseases, speaking many strange languages. The hospital was spartanly furnished with ancient, well-worn equipment. A Christian Medical Society's survey had told me that it was the best in Africa. I often thought with gratitude of my training at Yale under Dr Samuel C. Harvey who forbade anything but the most basic instruments in our operating rooms. I was able to close a vesico-vaginal fistula, perform a lobectomy for bronchiectasis, plus the usual less-demanding conditions. Anesthesia was ably administered with an ancient Boyle machine, by a 45-year-old all-purpose African medical assistant. His kind were the backbone of the English medical services in Africa.

The doctor whom I relieved amazed me by his ability to live, as Osler advised, in day-tight compartments, handling each day's problems as they came. He wasted no time. He never looked back. On my first day he put a patient in knee-chest position, took a snip of rectal mucosa, and with a cover slip and a microscope diagnosed within a few minutes the first case of schistosomiasis I ever saw.

It was Kenya's last year as a colony. The district hospital at

nearby Kisumu under the care of a well-trained internist looked good to me, and the government rural health clinics were running well under African medical assistants.

This being my first trip to Africa, I was starry-eyed. I rode behind a steam locomotive from Nairobi across the Rift Valley where the Mau Mau had recently been active, crossed Lake Victoria in the moonlight, and slept poorly in a tent on the banks of the White Nile surrounded by frightening animal sounds. In an electrical storm on the shore of Lake Albert I got lost at nightfall with a wife and two small children in a Morris Minor, and with two lions in the headlights. I expected to see Stanley or Burton or Speke, or at least Spencer Tracy stride through the tall grass to rescue us. No one came; the lions went away and we successfully followed a track back to camp.

Long ago I read a small book, *The Man Next to Me*, whose message to visiting physicians was to have their mental bags packed and ready to leave tomorrow. "Yes, we're glad to have you," say the local people; "you heal our bodies and meet a payroll which provides for our food and shelter, but . . ." My own advice to visiting physicians: "keep a low profile – you are just a pair of hands; find out what the people would

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like you to do, do it, keep your mouth shut and don't even *think* politics."

I liked Kenya and was beginning to consider a long-term commitment. But in spite of the attractions, the English language, the gorgeous country and climate, East Africa was just too far from home and too expensive for a family with five children, and the mores of a strict Protestant mission were too restrictive for us. My wife had to smoke up the chimney and the bottle of sherry lay unopened in a suitcase under the bed. Although my eleven years overseas and elsewhere have been spent in places with a Christian commitment, I am not an evangelizing missionary.

On our return from Kenya, a letter arrived from Mellon asking me to spend a month in Haiti. I did so in 1962 and again in 1963. In 1964 after much thought, with a reluctant but willing wife, and two children ages 11 and 12, we went to Hôpital Albert Schweitzer in the middle of rural Haiti where we remained for nine years. Monny, my wife, taught the children at home, through the eighth grade; then they came to the States and transferred successfully to Westown, a Quaker boarding school near Philadelphia. They returned to Haiti for every vacation and their years on that faraway island were happy ones.

It is difficult for me to write with restraint about my Hôpital Albert Schweitzer experience. It was an exhilarating, challenging and fulfilling life for a physician. I had a stream of very sick patients, many with diseases I had only read about, able and devoted colleagues, a working library, good equip-

ment, and a tolerant, watchful, knowledgeable chief, W.L. Mellon. The seven learning years I had spent in a white suit at Dartmouth and Yale now paid off. Whatever I had never done or seen I researched, occasionally bringing an anatomy book to the operating room. A skeleton hung beside me one day when I was faced with a spinal cord exposed from a camion accident. The patient walked out of the hospital with control.

In spite of having no respirators or sophisticated pulmonary function apparatus, I performed 500 operations for pulmonary tuberculosis, almost all being resections, with a 60-day mortality of 1.8%. The lesson here is the importance of pre- and post-operative care by the operating surgeon. I lived a two-minute walk from the bedside.

Although there was always a sprinkling of Haitian doctors, most of the physicians were from the United States. Nurses were chiefly Haitian but others came from Holland and Switzerland, and always Mennonites from the United States and Canada. There were three physicians on medicine, three on pediatrics, three on surgery, one anesthesiologist, one ophthalmologist, two in community health and one dentist. One position on medicine was filled by a resident from the University of Vermont, one on pediatrics from the University of Cincinnati, and one on surgery from Yale.

The eye service was staffed by a US-trained Haitian, but after several years he left and was replaced by senior residents on a regular rotation from Yale. The residents loved it, particularly the surgeons be-

cause they could operate on the whole body, not just between the diaphragm and the pelvis. The public health section was affiliated with the Harvard School of Public Health. We long-term staffers, far from the ivory tower, were kept up to date by a succession of bright residents and many short-term practicing physicians.

One vignette illustrates the pleasure of this student-teacher relationship. One day an infant appeared with a tracheoesophageal which fortunately, we diagnosed promptly. The Yale resident with us had completed a rotation with Dr Lawrence Pickett, a leader in pediatric surgery. I was an experienced thoracic surgeon, but had not done one of these difficult procedures in years. An Alphonse-Gaston Act ensued ending with my hands doing the operation, but Dr Michael Curci taking me through it. Back in 1945, I as the resident surgeon, taught Pickett, a fourth year student, and now 25 years later in the middle of that tortured land and thousands of miles from where we all learned, Curci taught Lepreau. The circle was closed. The patient did well.

From 7:00 AM to 7:00 PM the hot, humid days were jammed with productive patient care, but one could hardly call it "work" since the doctors were doing what they had gone to medical school for, without encumbrances. Infectious disease, both medical and surgical, particularly tuberculosis and malnutrition, were the most common conditions.

Tetanus patients demanded intensive bedside care and occupied many beds. We directed

our first formal public health program against tetanus in adults and newborns by massive immunizations, beginning with females over the age of twelve. Every Saturday morning for a year and a half one nurse headed a group of non-professionals to immunize 4,000 people. The number of cases of tetanus then dropped precipitously from a high of 626 cases in one year, thus making beds available for other patients. From the opening of the Hospital in 1957, through 1972, the mortality for 985 consecutive cases, excluding newborns was 22%. The mainstay of treatment was bedside care by specifically trained nurses aides. No machinery. For a comparable period there were 3,696 neonatal patients. Their mortality rate dropped steadily from 50% to 26% in 1972. The number of cases and mortality have continued to drop. These results illustrate again the salutary effects of public health and bedside nursing as was demonstrated so long ago by Florence Nightingale at Scutari in the Crimean War of 1853-1856.

Dr and Mrs Mellon and Miss Walborg Petersen, Superintendent of Nurses, set the tone and style of the institution which we all attempted to emulate. Dr Mellon spent his days in the countryside laying pipelines to bring water several miles from the hills to a village, or encouraging cotton culture, pig raising and the like.

For relaxation we read, listened to records, played tennis, invited newcomers to dinner and had a rare dance to a band that played the merengue until 2:00 AM. A weekend in a Port-au-Prince hotel was a luxury we indulged in only occasionally

because that trip meant a two-and-a half hour ride each way over a muddy or hot dusty road.

A chance meeting with Gordon Thomas, Director and Chief of Surgery at the Grenfell Mission in Newfoundland and Labrador resulted in my replacing him for a month in mid-winter. Ever since reading *Adrift on an Ice Pan* and other Grenfell writings, I had imagined myself dressed like Jack London mushing across the ice in a dog sled. In 1969 the only dog I saw was running beside my Skidoo, but the original health care system was unchanged; a chain of nursing stations along the coast now connected to the main hospital at St Anthony by radio and airplane in both winter and summer. At the top of Newfoundland I stood at L'Anse aux Meadows, the only archaeologically-proven site of Norse habitation in North America.

We were back in the States in June of 1973 and I immediately experienced the first of several re-entry difficulties. It was my 35th Harvard Medical School reunion and I clearly recall my mental anguish at seeing so much food wasted. My old colleagues in Fall River urged me to rejoin them, so I resumed private practice. They were generous, but the business of practice, the commercialism of our profession and the litigious atmosphere were disheartening, so I fled, one might say, to the Frontier Nursing Service in eastern Kentucky, so-called Appalachia, where I was the surgeon and medical director. This inspiring institution was founded in 1925 by Mary Breckenridge to deliver medical care and later to train midwives for the people in the hills and

hollows of that chronically-depressed area. She built a hospital in Hyden and a string of nursing stations one-day-apart by horseback. The one doctor used to make rounds weekly. In my day there were four doctors, and I made the nursing station and house calls in a Jeep, occasionally finding that the only access was through a stream bed.

I think a house call comes near to the ideal of a practicing physician. You cross the line from being just a physician to being also a friend. A few moments into a house call and you learn more about your patient, the status of his disease and the household relationships, than you might ever learn in an office. Look around the room. The cat that you never heard about may be causing the asthma. Open the fridge and see the beer. Take the lid off the pan on the stove and see the chunk of pork rind floating amongst the shucky beans of your hypertensive patients. Physicians and patients are both losers without house calls.

At Frontier Nursing Service I again had the privilege of working with a cadre of dedicated professionals, this time almost all nurses. The idealism of the staff had a strong appeal, but for Monny and me eastern Kentucky was not an area where we could comfortably finish our lives.

We decided on Westport, where I joined an old friend, Dr Stewart Kirkaldy, in his family practice. I knew a fair amount but had been away a long time. He brought me up to reasonable competence and I did the surgery. We developed an affiliation with Massachusetts General Hospital to train and

subsequently employ his office nurse as the first certified nurse practitioner in the area. She continues to be a great success. We created Westport Family Medical Center, a true group now comprising seven family practitioners. Here, thanks to Doctors Stanley Aronson and David Greer I have had the opportunity to be a preceptor for Brown medical students on their community health rotation.

One day in 1977 a recently-retired Episcopal priest, Jones Shannon, came into my office and said, "I am full of energy. Any ideas?" I told him about Hospice which a college roommate was initiating in New Haven. Reverend Shannon, who had a business career before he took the vows, was the ideal person to pioneer this new concept that some people thought infringed on their turf. Hospice in Fall River has burgeoned and all now acknowledge its contributions. It was my idea and I tagged along, but Jones Shannon put it across.

In 1977 Mrs Ricky Alpert and Mr Edwin Jaffe asked me to join them as medical director to open 20 beds to dry out alcoholics in the long-abandoned Fall River municipal tuberculosis hospital. The building was a wreck, but with much community support it was made habitable. Steven Gavigan, the first head nurse, had his mother mopping floors and cleaning radiators. The institution flourished and now the present director, Nancy Paull, has expanded the services to 70 inpatient beds for detoxification and rehabilitation of all types of chemical dependency. This fall we expect to open five beds for a one-year residential treat-

ment of pregnant addicts and their newborns.

In 1979 when I was "Quaker in Residence" for a short time at Beacon Hill Friends House, one of the young women took me to the dingy basement of the Arlington Street Church where three people were listening, listening, to long telephone calls. It was the Samaritans in action, originated by Chad Varah in England and brought to this country by Monica Dickens, the granddaughter of Charles Dickens. We brought Ms Dickens to Fall River and made an abortive attempt to establish a Samaritans unit. In 1983 Ricky Alpert revived it and assumed the leadership of the program, the fourth in the nation, now serving New Bedford, Fall River and many surrounding communities.

I have always thought well of nurses. As an intern they taught me techniques, medications and bedside care. As a resident, by their silence they rebuked me for verbal explosions in the operating room. In private practice, when my first big case was going bad at 2:00 AM they were running all over the hospital to get equipment, and at the bedside checking, checking, checking the meds, the IVs, the machinery, but mostly check-

ing me. There is a long, long list of patients who will never know how a nurse made their surgeon look good. From my overseas experience and right up to now, where I am the only doctor for a 70-bed public institution, I am further convinced of the valuable contribution that non-doctors make to the care of the sick. So many of us neglect to encourage the full expression of their ability.

Physicians are among the fortunate few who can choose where to live in reasonable comfort, so what is so good about service in a faraway country? A fair question with a different answer from everyone. For me it was the opportunity to live an uncluttered life and to practice my craft where it would make a difference, unburdened by lawyers, insurance forms, committee meetings and telephones. And finally, perhaps it was the romantic appeal of tropical life amongst bougainvillea, hibiscus and oleander – but not so romantic when the rats and cockroaches became too friendly.

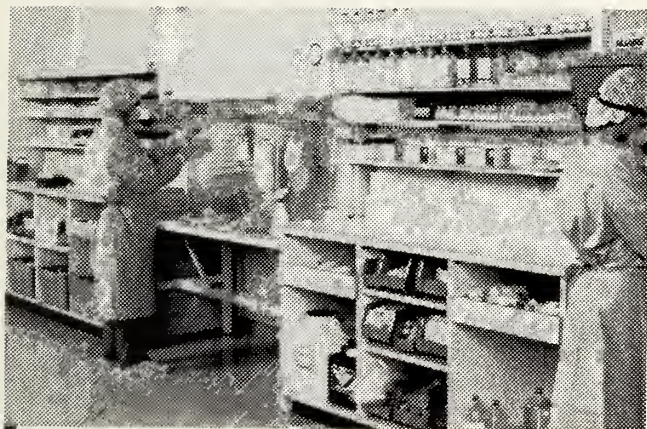
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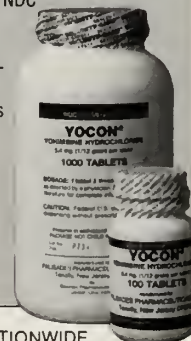
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June 20 - 24, 1991
Chicago Marriott Hotel
Chicago, Illinois**

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- presentation by the AMA-HMSS Governing Council of reports on medical staff issues including Evaluation of the Hospital Medical Director and Criteria for Evaluating the Performance of the Hospital Medical Director, PRO Required Education of Hospital Medical Staff and Patient Responsibility of On Call Physicians;
- an information exchange on PRO and Managed Care Review;
- AMA-HMSS Governing Council elections for the positions of Delegate, Alternate Delegate and one Member-At-Large.

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American Medical Association
515 North State Street
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HMSS

Biography of Francis H. Chafee, MD

December 12, 1903-April 24, 1990

Guy A. Settipane, MD

Among Seebert J. Goldowsky's many friends was Francis Chafee, a most respected colleague in the field of clinical allergy.

Francis Chafee was born in Providence, Rhode Island, the youngest son of Zechariah and Mary Dexter (Sharpe) Chafee. He loved New England, and was a lifelong resident of Providence. He graduated from Brown University in 1927 and Harvard Medical School in 1931. He was the founder and director of the allergy clinic under the Department of Medicine at Rhode Island Hospital from 1938 to 1965; also he was one of the founders of the Rhode Island Society of Allergy, the Sneeze, Wheeze and Itch (SWI) Club, and the New England Society of Allergy. He served as President of the Providence Medical Association, New England Society of Allergy, Rhode Island Society of Allergy and Vice President of the American Academy of Allergy and Immunology. He volunteered in the Army Medical Corps in World War II and served in Europe for 3 years, attaining the rank of major.

His talents were not limited to the medical field. He was a knowledgeable astronomer and an active member of the Smithsonian Special Alert Team to investigate sudden phenomena. He was a historic collector

par excellence; his early book collections are legendary. He began purchasing Bowditch early navigational books for a few dollars while in medical school and upon his retirement donated the entire collection to the prestigious John Carter Brown Library at Brown University where they are held to be a very valuable asset.

His interest in navigation and sailing dates back to his college days when he spent a large part of the summer sailing up and down the New England coast. Subsequently, he had a summer home in Maine, and there continued sailing up to a year before his death. He taught me how to sail in a 3-hour grueling, tempestuous ride on Long Island Sound in my newly-acquired O'Day sailer.

Among his great assets were his sensitivity, compassion, and concern for mankind and for education. He loved people and always tried to help those in need. A humanist, he spent over 20 years voluntarily giving his time and care to the needy two mornings a week at the Rhode Island Hospital Allergy Clinic. He enjoyed teaching; indeed he was one of my significant mentors. Gratefully his former residents established the Francis H. Chafee biannual Oration during his lifetime.

He sought the best in everyone. Of Billy Buffum, Francis

said, "He was one of the kindest men I had ever known." Of Lewis Webb Hill he said, "He was one of the most honest physicians I knew." Of Francis Rackeman he said, "He was one of the smartest physicians I have known."

In politics he certainly was a liberal, especially when it came to socioeconomic problems of the poor. If he believed that a cause was just, he would campaign to the fullest. He mobilized physicians to suggest to Brown University that William Buffum merited an honorary degree, especially with all that Billy accomplished while being almost totally deaf. This was done. He campaigned to have more representation of practicing allergists on the Executive Committee of the American Academy of Allergy and Immunology and with the voice of the Rhode Island Society of Allergy behind him, this was accomplished.

He was fiercely loyal to his friends and schools. He was instrumental in having a large sum of money from his mother's charitable foundation (Mary Dexter Chafee Fund) given to the new library at Brown University. He was a guest mediator of town and gown controversies and became a respected and close friend of several leading Brown University professors. One such friendship enabled him to

decipher a historical myth in allergy. The belief was that the first recorded death from a wasp sting was that of an ancient Pharaoh. A professor of classics at Brown University in deciphering the appropriate hieroglyphics found evidence for considering the myth spurious. Apparently, the Pharaoh died through an encounter with a hippopotamus, a confusion in the nomenclature.

For a practicing physician, he produced as an author or coauthor 29 research publications. His topics ranged from the "origin of the definitive subclavian artery in the chick embryo" (in 1928) to the pregnant steroid-dependent asthmatic patient and perinatal mortality (1989).

His other research reports dealt with eosinophils in fatal asthma, pollen and mold surveys, reactions to drugs and food additives, insect sting allergies, adverse reactions to aspirin, nasal polyps, and treatment of allergy during pregnancy. Some were published in the prestigious *New England Journal of Medicine*, the *Journal of Allergy and Clinical Immunology*, and the *Annals of Internal Medicine*, a noteworthy accomplishment for a physician who devoted 95% of his professional time to the practice of allergy/immunology. He applied everyday information from clinical medicine to research questions and became the epitome of the best of both pursuits.

His everyday folksy philosophy was appreciated by many. In finances, he stated, "It is not a matter of making money, but a matter of trying to keep what you got." His advice for those parents with adult children was,

"It is a good idea to keep your mouth closed and your pockeibook, opened."

His best known qualities are his enthusiasm for mankind, eleemosynary academic institutions, charitable causes, scientific endeavors and pedagogic activities, all of which are ineffable, but extremely contagious.

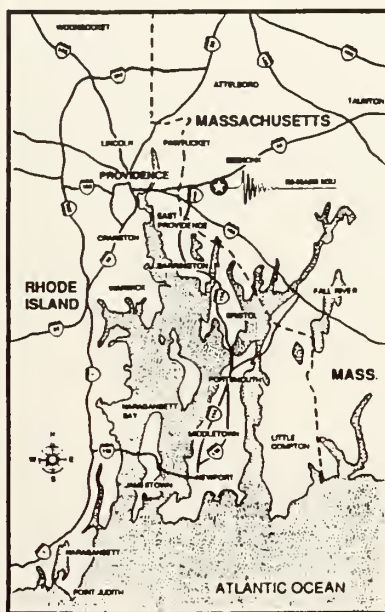
Reprinted with permission by Allergy Proceedings, September-October 1990, Vol 11, No. 5, pp. Those who are interested in a complete bibliography of Francis Chafee may refer to this publication.

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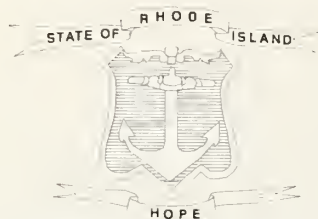


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HEALTH BY NUMBERS

Rhode Island
Department of Health
H. Denman Scott, MD, MPH
Director of Health

WIC Program Expansion: Meeting the Needs of the High Risk Population

The Rhode Island WIC Program is a federally-funded, state-administered program that provides nutritional counseling and nutritious foods to women who are pregnant, breast-feeding or postpartum and infants and children under age five. The purpose of WIC is to supplement good health care in order to prevent nutrition-related health problems among low-income mothers and children. Participants must be Rhode Island residents with limited income and be at some documented biomedical or dietary risk.

Recently a competitive bid process to purchase infant formula at reduced rates allowed the expansion of caseload from 14,566 in early 1988 to 15,955 in May of 1990, an increase of 10%. Throughout this expansion period there has been a notable shift toward serving higher priority applicants, a result of WIC Program efforts to reach those persons at highest risk and the medical community's assistance by prescribing breast milk or the contract brand of formula for infants on the WIC Program.

Since Program funds are only suffi-

cient to serve about 50% of the persons meeting the income and nutritional risk eligibility criteria, applicants are assigned a priority level based on risk factors and developmental lifestage. Highest priority (Priorities I, II and III) is assigned to applicants with biomedical risk factors, including poor obstetrical history, poor growth and development, and low blood iron.

Lower priority (Priorities IV, V and VI) is assigned to applicants with dietary inadequacy risk factors, including consumption of a diet low in total calories, or in key nutrients such as protein, iron and calcium. In addition, pregnant and breast-feeding women and infants are considered to be at higher risk than postpartum women and older children. When there are more applicants than the Program can serve, those at higher risk are served first.

Overall, the total increase in the caseload was accompanied by an increase in the proportion of clients in the three highest priority groups; now 75% of the caseload versus 61% in 1988 (figure 1). The largest percentage in-

creases occurred in the categories of pregnant women (+52%), high priority (group III) children (+39%) and high priority (group I) infants (+28%). The four highest risk priority groups all increased during this period, and the two lowest priority risk groups both decreased, while the total caseload was increasing by 10% (Figure 2).

While serving more people and a higher percentage of the needy eligibles, WIC in just two years has more efficiently and effectively targeted its resources to serve a higher proportion of those persons with the greatest need for nutritional supplementation and education among Rhode Island's women, infants and children.

To accomplish this shift, outreach activities such as public service announcements, billboards, and communication to medical providers were geared to enroll pregnant women, particularly those at high risk, as early in pregnancy as possible. The Program targeted its resources to areas previously identified as having high levels of risk over time as well as higher current levels of demand.

Figure 1. Percentage Breakdown of WIC Caseload by Nutritional Risk Priority Group, Rhode Island, March 1988 - May 1990.

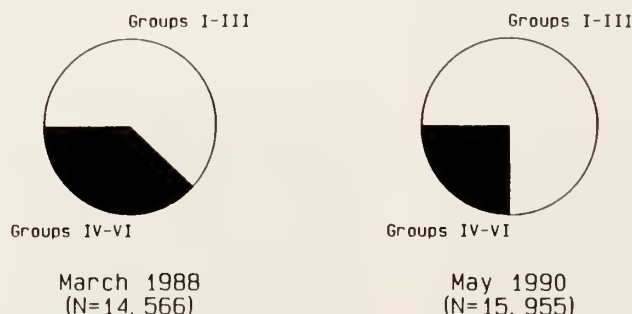
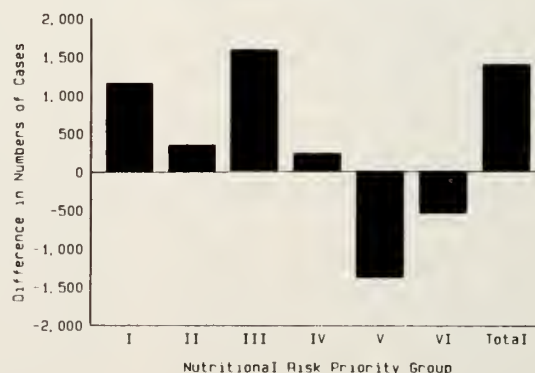


Figure 2. Change in WIC Caseload by Nutritional Risk Priority Group, Rhode Island, March 1988 - May 1990.



Submitted by the Office of Supplemental Nutrition (WIC), John L. Smith, MSW, Chief. Health by Numbers is edited by Jay S. Buechner, PhD and William J. Waters, Jr, PhD.

Monthly Vital Statistics Report

Provisional Occurrence Data From the Division of Vital Records

H. Denman Scott, MD, MPH
Director of Health

Roberta A. Chevoya
State Registrar

Vital Events	Reporting Period	12 Months Ending with December 1990	
	December 1990 Number	Number	Rates
Live Births	1,234	15,956	16.0*
Deaths	872	9,705	9.7*
Infant deaths	(6)	(120)	7.5#
Neonatal deaths	(3)	(93)	5.8#
Marriages	437	8,145	8.2*
Divorces	236	3,754	3.8*
Induced Terminations	582	7,798	488.7#
Spontaneous Fetal Deaths	92	1,190	74.6#
Under 20 weeks' gestation	(80)	(1,103)	69.1#
20+ weeks' gestation	(12)	(86)	5.4#

*Rates per 1,000 estimated population

#Rates per 1,000 live births

Underlying Cause of Death Category	Reporting Period	12 Months Ending with September 1990		
	September 1990 Number (a)	Number (a)	Rates (b)	YPLL (c)
Disease of the Heart	235	3,487	349.4	5,215.0
Malignant Neoplasms	202	2,460	246.5	7,081.0
Cerebrovascular Diseases	50	595	59.6	702.0
Injuries (Accident, Suicide, Homicide)	34	448	44.9	9,928.0
COPD	23	385	38.6	429.0

(a) Cause of death statistics were derived from the underlying cause of death reported by physicians on death certificates.

(b) Rates per 100,000 current estimated population of 998,000.

(c) Years of Potential Life Lost (YPLL)

NOTE: Total represents vital events which occurred in Rhode Island for the reporting periods listed above. Monthly provisional total should be analyzed with caution because the numbers may be small and subject to seasonal variation.

THE RHODE ISLAND MEDICAL JOURNAL

The Official Organ of the Rhode Island Medical Society
Issued Monthly under the direction of the Publication Committee

VOLUME I
NUMBER 1

PROVIDENCE, R. I., JANUARY, 1917

PER YEAR \$2.00
SINGLE COPY, 25 CENTS

THE RHODE ISLAND MEDICAL JOURNAL HERITAGE

Ninety Years Ago

*(Providence Medical Journal
April-June, 1901)*

The lead editorial decries the splitting of fees between physicians and opticians, observing "It is strange that anyone should expect to find a physician so false to his professional honor that he would for a moment consider such a proposition." The editorial then concludes with the following appeal: "This is not, however, a plea for special legislation, but an appeal to the profession of this state to discourage the practice of consulting incompetent men for ocular defects. What would be thought of the man who, on finding that his patient was suffering from a cutaneous disease or nervous affection which he did not feel competent to treat, should advise him to go to the drug store and get them to give him something for it? Yet this is exactly what they do when they tell their patients to go to an optician and see if their eyes need attention; and very many physicians are in the habit of doing

just that thing."

This issue of the *Journal* summarizes the recently completed 1900 US census, the twelfth undertaken since the nation was established. The total population of the state is now 428,556, having risen 24% in just one decade. The three largest cities (Providence, 32.9%; Pawtucket, 42.0%; and Woonsocket, 35.4%) show the greatest growth rate, partly through natural increase, partly through immigration and partly through annexation of local communities. A few towns, notably Barrington, East Greenwich and West Greenwich, are decreased in population. The greatest growth rates in the state are encountered in Cranston (64.8%) and East Providence and North Providence (each 44.9%). This population expansion is attributed, in some degree to the recent development of the state trolley system which will allow workers to live further distances from their work-places and will thus, "... do much to prevent the growth of unwholesome tenement conditions in our cities."

The third editorial discusses the physician's duty as to vaccination. "Are we not as physicians in a measure remiss in not making sure that the families of those in our charge are protected from small pox by being properly vaccinated?" It concludes: "Now what may the physician expect to receive for his advocacy of vaccination? Nothing, save more or less of trouble and very inconsiderable fee for the operation if he himself does the vaccinating, but in it all he is unmistakably a public benefactor."

A fourth editorial implores the physician to employ the proven means of preventing ophthalmia neonatorum (typically due to maternal gonorrhea), and to apply greater diligence when it has once occurred. The editorial notes that during the previous year, the Rhode Island Hospital has admitted eleven cases. Eight eyes were lost and, "... so far as could be ascertained, but one of the children had received any adequate attention till it was too late to preserve the eye."

The minutes of the quarterly

meeting of the Rhode Island Medical Society are summarized. The present active membership is 252 and the treasury remains in satisfactory condition (balance on hand, \$887.11). Officers for the year are: G.G. Keene, W.R. White, C.F. Baker, F.L. Day, H. Terry and F.T. Rogers.

The major scientific paper is an extended inquiry into the often subtle diagnostic distinctions between appendicitis and typhoid fever. It is written by Maurice H. Richardson, MD of Boston. The author concludes: In rare instances an appendicitis, in which the abdominal symptoms are mild, may stimulate a typhoid in which they are pronounced. The symptoms which should put the surgeon on his guard against typhoid include... pain and tenderness without rigidity or tumor; a history of malaise, headaches, slight fever preceding the pain; an initial and sustained temperature of 103° or more preceding the pain; increased area of splenic dullness; rose spots; normal leukocyte count. Sometimes the diagnosis cannot be made. "It will almost always be safe to wait, and the surgeon should wait from the absence of rigidity and tumor typhoid is suspected, especially if the patient is near at hand. Twenty four hours will usually be time enough to establish the diagnosis of appendicitis or rule it out. Many days may be necessary to recognize positively typhoid fever."

Fifty Years Ago (April, 1941)

The lead article is the Provi-

dence Medical Association Presidential Address given by J.G. Walsh, MD. The speaker summarizes the many activities of the Association during the prior year, and also notes: "The rapid and almost revolutionary changes that have taken place in American life in the past few years following the profound economic depression of the early thirties, have seriously threatened the professional and economic welfare of those engaged in the practice of medicine. From many sources all sorts of reforms have been proposed. The older members of this association can look back and realize the progressive changes that have taken place in medical practice as scientific knowledge has increased. But these changes have been made in such a way that the relationship between the private physician and the patient has been strengthened rather than disrupted. Although the National Health Act introduced into Congress in 1939 has been shelved for the time being there is no reason to believe that it or some similar bill may not soon reappear to plague us. It is in measures such as this, that the doctor-patient relationship is being seriously threatened."

Drs C.C. Dustin and H.L.C. Weyler present a paper entitled Coarctation of the Aorta Associated with Pregnancy. They note that there are prior 29 cases of coarctation and pregnancy in the medical literature. Previous authors have concluded that "pregnancy had a deleterious effect in over one-half of cases." The current case report concerns a 17-year-old woman with a prior history of unusual cardiac murmurs. She

was seen during the first trimester of her pregnancy. Numerous physical findings and differential blood pressure readings (hypertension confined to the upper limbs) suggested aortic coarctation; X-rays of the chest supported the impression of coarctation of the aortic arch. The patient developed a bacterial endocarditis, lapsed into coma and died. No autopsy was performed. The authors comment: "The electrocardiograms in coarctation of the aorta have no characteristic identifying features. If there are associated abnormalities placing appreciable strain on the heart, there may be right or left axis deviation, the type and degree of deviation depending upon the functional disturbances. Since arterial hypertension in the upper part of the body is a characteristic finding, one would expect to find left axis deviation. Cases have been reported with normal axis."

H.K. Turner, MD reports on Chemotherapy in Infections of the Genito-urinary Tract, describing its present status. "It would seem that sulfathiazole is in every way superior to the others. At a concentration of 20 mgms per 100 cc of urine it will cure practically all infections in the urinary tract in which there is no underlying mechanical difficulty such as a foreign body, residual urine or a hydronephrosis."

Drs M. Cutts and B.E. Clarke present a clinical pathological conference on a 69-year-old woman with a papillary carcinoma of the gall bladder.

The lead editorial celebrates the tenth anniversary of the Emma Pendleton Bradley Home. It describes the Home

as an institution devoted to the study and care of children suffering from nervous disorders, and its trustees (including Drs Charles V. Chapin and Arthur H. Ruggles) as farseeing in making certain that the Home was established as a hospital, operating under medical direction and accepting as patients only children referred directly by practicing physicians. The editorial observes that during the depression years, 50% were treated below cost, and an additional 30% paid nothing.

Another editorial entitled *The Medical Home Guard*, states: "In the event of a national emergency, in which the armed forces of the United States are mobilized, a large number of medical men, now in civilian life, will be commissioned as officers and will serve as such; but the entire profession will be called into service."

"Modern warfare, or "total war" as it has been called, now is directed against entire populations. At the present time a London hospital orderly faces more danger than a British infantryman, and his work is of equal importance to his country. When the medical profession of this country is mobilized, every doctor will be involved, and in the city, in the country or with the armed forces each will have ample opportunity to do his full share."

The Rhode Island Medical Society income for 1941 (exclusive of certain bequests and investments) is projected to be \$6,236.50 and its budgetary expenses, \$6,582.00.

The chief editor of the *Rhode Island Medical Journal*, for the year 1941, is Albert H. Miller, MD and the associate editors are Drs C. Bradley, W.P. Buffum,

A.M. Burgess, F.H. Chafee, F.B. Cutts, J.H. Gordon, J.C. Ham, J.W. Helfrich, A.M. Tartaglino, E.D. Thompson and G.L. Young.

Twenty Five Years Ago (April, 1966)

This issue is devoted, almost in its entirety, to a symposium on cerebral vascular accidents, with the following participants: Drs M.N. Fulton, J. Stoll, Jr, C.M. Fisher and W.C. Cotter. Fisher lists a group of indispensable questions when approaching the stroke patient. Has the patient really had a stroke? Is the stroke a hemorrhage or an infarct? In what vascular territory is the stroke? Is there hemiparesis or hemiplegia? Is the stroke purely sensory? Is the stroke due to lacunar infarct? Has the stroke reached its maximal clinical manifestations? And, should an arteriogram be performed? Stoll, describing the neurosurgical contributions in the treatment of stroke, lists those lesions, such as cerebral aneurysm and arteriovenous malformation, where such intervention is appropriate. In addition, he points to surgical repair of partial occlusions of the carotid artery as an area where additional contributions may be made. Cotter discusses the subclavian steal syndrome and indicates that cerebral embolism may also be amenable to surgical management.

N. Sonkin, MD writes a paper indicating that there is a risk of bleeding from the eardrum in individuals receiving anticoagulants who are then subject to gunshot blast.

A. Porter, MD in his capacity

as president, writes the annual report of the Corporation of Rhode Island Medical Society Physicians Service.

J. Cannon, MD and L.L. O'Hara summarize the Rhode Island vital statistics for the year 1965. The number of live births is the lowest since 1950 and parallels the nationwide decrease. Neonatal and infant mortality rates also drop. The five leading causes of death are: heart disease, malignant neoplasms, cerebral vascular disease, accidents and influenza/pneumonia.

The principal editorial expresses concern that the Charles V. Chapin Hospital is to be closed by the city of Providence without making adequate preparation for the transfer of its functions to other institutions. "While an excellent institution is being allowed to founder, the talk goes on and irresponsibility prevails. They fiddle while Rome burns."

Another editorial notes that 49,000 Americans died on the highways during 1965. The Federal government now requires the following features for vehicles which it purchases: stronger seat belt anchorages, padded dash and sun-visors, safety door locks and hinges, recessed dash instruments and knobs, strongly anchored seats, four way directional signals, dual braking, standard bumper heights, standard automatic gear shift indicators, two-speed windshield wipers, glare-reducing dashboard surfaces, safety tires and rims, back-up lights, outside rear-view mirrors, impact absorbing steering wheel shaft.

BOOK REVIEW

Bedside Medicine

Essays on the Rise and Decline of Bedside Medicine.

Mark D. Altschule, Philadelphia-London, Lea & Febiger, 1989.

Robert V. Lewis, MD

It is most appropriate to honor Seebert J. Goldowsky, MD with this review of medical history by Mark Altschule, his friend, classmate and fellow historian. This review was requested by Dr Goldowsky just before his retirement.

A knowledge of the man, Mark Altschule, will greatly enhance the pleasure of his essays. Many will have known him during his professional life spent entirely at the Harvard Medical School and its affiliations. Richard Wolfe, Curator of Rare Books and Manuscripts at the Countway Library has said "Mark was uniquely unique with creativity and insights that few are privileged to have". "Essays on the Rise and Decline of Bedside Medicine" and an earlier collection of essays, "What Medicine Is About" are concerned with the practice of medicine, what it is and what it should be.

What are Mark Altschule's credentials and qualifications, so we may evaluate his judgments and biases? He was a scientist, physician and creative artist who was not split into one of C.P. Snow's Two Cultures. He might properly be termed a renaissance man or in the current vernacular, a polymath. Born in 1905 on the

lower east side of New York, he graduated from the City College of New York in 1928 intending to be a biology teacher. After two years in the laboratory at Mt Sinai Hospital, he entered Harvard Medical School and graduated cum laude. He was professor of clinical medicine and his research is contained in over 300 papers which cover the entire field of internal medicine. He wrote a classic in 1950 entitled "Physiology and Diseases of the Heart and Lungs". Papers on aberrations in mental disease, the first significant study of the pineal gland, studies in carbohydrate metabolism especially in stress, all illustrate the breadth of his interests.

As a teacher he was unexcelled, not only by his encyclopedic knowledge of the science of medicine, but the history of medicine. With unmuddled thinking he approached all clinical problems by beginning at the patient's bedside. But he was much more than just a physician. He was already an accomplished woodcarver in his teens. While a student at Harvard Medical School he supported himself by working at the Beth Israel Hospital laboratories, but also found time to continue instruction in sculpting. His interest in

the biochemical and physiological alterations in mental disease led him to collect over 600 volumes on the history of psychiatry from antiquity to the present. These he donated to the Countway Library. At the time of his death, he was Honorary Curator of Prints and Photographic Collections. This amalgam of so many facets made him the bedside clinician, medical researcher, and medical philosopher which makes what he has to say in "Essays on the Rise and Decline of Bedside Medicine" worth listening to while enjoying the pleasure of his erudition, wit and style.

Altschule prefaces his work with the report to be a traditional history of medicine. The making up of lists of concepts that marched along the road of history pushing the ones before them off the road can only produce historical accounts that although popular are misleading". He shows in his survey of bedside medicine from the 17th Century to today the theories of disease which to many of us may now seem follies as they have occurred in the past 400 years. He also suggests that we too may be subject to present day follies. The classical theory of humors, the iatrochemists, the iatro-

mechanics are glaring past examples. The acceptance of preconceived notions rather than pragmatic observations have led to such follies as bleeding to let out "evil humors". One may easily reflect on his own medical school training to realize how didactic teaching unsupported by careful clinical observation has led to fads in medicine and what we may regard as ridiculous treatments, such as sympathectomies for hypertension.

Prior to the study of medicine at the bedside which was begun by da Monte in 16th Century Padua, medical education was entirely didactic based on medical authority such as Galen rather than by observation. It was a Dutch student at Padua, van Heurene, who took the concept of direct bedside observation to Leyden after anatomy and postmortems had been banned by the Church in Padua. He taught anatomy, medicine and surgery as early as 1601 and bedside instruction twice weekly was in full vogue in 1630. But it was Boerhaave who established clinical bedside medicine as we understand it, at Leyden. So successful was Boerhaave as a teacher and his methods so productive that his students were called to professorships at all the important medical schools in Europe in the 17th Century. He was called *communis Europae praeceptor*, the teacher of all Europe. His students founded the University of Edinburgh and the second generation, the first medical school in America, at the University of Pennsylvania. Bedside medicine in the last analysis is careful history tak-

ing, meticulous physical examination and the objective evaluation of therapeutic measures, not only observed in the living but by correlation at autopsy which in most instances was performed by the physicians themselves. In England, Sydenham was the great bedside observer, recorder and writer. It is significant that he had very little formal medical training and his work and position were purely the result of astute observation, correlation and interpretation. Galenical concepts in practice were for those formally educated, and consequently were burdened by the errors in Galen, many of which should not be charged against Galen, but to his interpreters.

Altschule gives a unique history of medicine from 1600 to the present day by describing medicine as it was practiced rather than by the methods of Garrison and Castiglioni who record the biography of physicians and their significant discoveries in the field of medicine. The author clearly distinguishes between significant events as conventionally portrayed and what the practice of medicine actually was at the time of the discoveries and thereafter. He cites as a significant example that Harvey's demonstration of the circulation of blood had very little bearing on the actual practice of medicine in Harvey's day or for some time thereafter.

The book is divided in two parts, Part I - Through the Anglo-French Enlightenment; and Part II - Austrian and German Influences in 19th Century Medicine.

Replete with names in English medicine, and vignettes related to them, one is treated

to a rich cultural history not only of medicine but of contemporary times. Seventeenth Century England was notable especially for Sydenham, Boyle, Locke and Hook, all physicians many of whom will be recognized in fields other than medicine. Gilbert, for example, is remembered mostly for his *De Magnete* and Locke was one of England's leading philosophers of the era.

Altschule emphasizes the importance of gross anatomy followed by the autopsy which was necessary to refute the theoretical Galenical medicine as it was taught in all the so-called medical schools at the time. Versalius, Pare, Giovanni Battista Morgagni, William Hunter and Baillie, a house pupil of William Hunter, illustrate the importance and effect of anatomy and postmortems.

Clinical medicine in the 18th Century came to full flower in the University of Edinburgh, the daughter of the University of Leyden, and Boerhaave. The names there are almost household words—Pringle, the Monroes, Cullen, Whytt to mention but a few of the great clinicians in Scotland.

At the same time England was distinguished by the names of Heberden, Mead, Sims, and of course, Withering. This latter name Altschule uses as an example of the necessity for broad intellectual curiosity and reactivity as essential characteristics of the ideal physician. Withering's prime interest was the study of the flora of England. His use of digitalis and his clinical result again illustrates the pragmatism, the careful observation, and recording of effects. His book on the subject of English flora is

as remarkable as his use of foxglove. Pott, John Hunter and Jenner were all contemporaries. Altschule expounds on the type of mind that makes for the better physician. Jenner is equally well known for his knowledge of natural history and his collection of fossils, his poetry and his reputation for playing the flute and violin. The ability to see, interpret and then experiment was the mental process that allowed Jenner to interpret that the milkmaids of Gloucestershire never developed small pox even when inoculated with it if they had cow pox. Altschule notes that the type of curiosity that led Thomas Young to decipher Egyptian hieroglyphics and write the natural history of the cricket is the same as that used to observe and practice bedside medicine. In 18th Century London all five hospitals taught bedside medicine.

Earlier it was stated that Boerhaave was the father of all the professors in Europe. van Swieten went to Vienna where he was called by Maria Theresa. He is best known for his commentaries on the Aphorisms of Boerhaave. Altschule shows that despite his training at Leyden he became rigid, lost the pragmatism of his teacher and medicine in Vienna failed to grow. Gottingen was made famous by Frank and Von Haller. Daily ward rounds were obligatory for Franks' students. Auenbrugger is another of Altschule's total man. There were Sunday afternoon musicals in his home, and he wrote the libretto for Salieri's "Chimney Sweep".

French medicine beginning before the revolution was the embodiment and full flower of

the Enlightenment. Lavoissier, Jaucourt, Desault, de Rochefort, de la Mettrie, de Tracy and de Fourcroy brought honor to France. Eighteenth Century French medicine was however chiefly materialistic and influenced greatly by Descartes and his Yatro-mathematical School and then by the iatrochemical, influenced to some extent by the work of Lavoissier on respiration.

In 17th and 18th Century France, the hospitals in France were huge, having hundreds of beds. It was a natural consequence that the clinical material was there. The emphasis on bedside medicine led to French pre-eminence. It was here that percussion and auscultation were practiced and perfected. It was an age peppered by great names common to all of us, Pinel, Bichat, Corvisart, Laennec and Poiseuille. By 1850, France had perfected physical diagnosis done entirely by its postmortem correlations; and the beginning of laboratory studies influenced in the beginning by Lavoissier had begun.

We are not so apt to think of the influence of Irish medicine; but it was real. To recall the names is sufficient to illustrate the point: Colles, Cheyne, Adams, Graves, Corrigan.

In London during the 19th Century, the hospitals – St. Bartholomew's, St George's, St. Thomas' and Guys – were the setting for the extension of bedside teaching. Illustrative of Altschule's knowledge of medical history and commentary is his observation that Florence Nightingale began nursing teaching at St. Thomas' at which time it was greatly feared that

the education of nurses would lead to their taking over the practice of medicine. It was the century of Bright, Hodgkins and Addison. The name Bence-Jones illustrates the importance of the emerging science of laboratory medicine.

Nineteenth century Germany saw an attempt to systematize medicine and there was a school known as the "Natural History School" in which diseases were classified very much as in the method of Linnaeus. Schonlein was the professor at Berlin who popularized "medical philosophy". Nineteenth century German medicine saw the exposition of the ideas of Virchow and Cohnheim who established the concept of medicine as physiology based on physiochemistry and was known as *innere Medizin* which was the beginning of internal medicine.

Every city had its day – Leyden, London, Edinburgh, Paris and Vienna. Viennese medicine should have been in the tradition of Boerhaave and was in a sense when Carl Rokitansky so greatly expanded the clinical pathological correlations with the unbelievable 80,000 postmortems performed in his lifetime. Of cultural interest is that his first autopsy was performed on Ludwig van Beethoven. There were Skoda, Hebra, Krafft-Ebing, and Freud.

Medicine in America in colonial times was influenced by the students of medicine who went to Edinburgh and came back to found the Medical School of the University of Pennsylvania. Shippen, Rush, Morgan, Bond and Bard all are witnesses to their Edinburgh education. Following the Revolutionary War, however,

American physicians went primarily to Paris and by the middle of the 19th Century, the American Medical Association had held its first meeting and voted to commend that all medical schools have university connections. The need for bedside training officially came to be recognized everywhere in the country. At Harvard, Holmes and Bigelow introduced physical diagnosis, clinical medicine, and wrote textbooks. However, through the first half of the 19th Century, French medicine attracted hundreds of Americans and other foreigners to study under Charcot, Binet, Duchenne and Marie. German physiologic brilliance was spent on "Scientific Materialism" demonstrated by the works of Wasserman and Ehrlich. All influenced American attitudes towards the practice of medicine and the importance of incorporating science into the medical schools.

The German influence on American medical education is illustrated by Altschule in the Flexner report. With Americans now studying in Vienna and Germany, they brought back the belief of the evangelizing German academic physicians that science was the essence of medicine. They brought back the idea that hospitals should be appendages to a medical school employing full-time physicians. The idea of founding such a new school resulted in the Johns Hopkins University Medical School. Altschule is highly critical of the Flexner report. He states that the instrument "gave German reductionist medicine its dominating position in American medical education". Altschule's opinion is that the first part of the

Flexner report is sound but elementary and verbose. The second portion of the report he considers was probably written by somebody else. The report created a sensation and resentment amongst medical educators and physicians. The American Medical Association had already reported on its inspection of medical schools and had already closed many of them. His main criticism is that Flexner gave no indication of establishing what was good medical practice and made no effort to prove its dependence on what he had come to believe was the only good medical education based entirely on the German school. The main portion of the report was that American medical education should be controlled by universities with all the faculty salaried. Altschule concludes that a university connection is advantageous to a medical school, promises but does not guarantee academic stability and financial security. "Further, the propensity of some universities to support old dogmas or to adopt new ones is common but not universal. This need not affect medical education adversely as long as the university connection does not impair the function and independence of a medical school's clinicians."

In his epilogue, Altschule summarizes the varied and at times unconnected "Essays". He maintains that throughout history the excessive and uncritical use of the laboratory has impaired clinical practice by attenuating the doctor/patient relationship.

The physician in the setting of bedside medicine is essentially a primary care physician.

Peabody, an early Harvard professor, wrote: "The treatment of a disease may be entirely impersonal; the care of a patient must be completely personal". In this reviewer's mind, the tendency for the practice of medicine to become increasingly impersonal arises from the sophisticated specialization, techniques, and modalities of treatment which are totally impersonal and to a very large extent reduces what we commonly consider the "care of a patient". The skilled ophthalmologist who restores a patient's vision with an implant or the elimination of angina by correcting coronary artery flow illustrate that impersonally treating the disease eliminates the need to "care" for a suffering patient unrelieved of his problem. Similarly, the diagnostic modalities such as CT, MRI and computerized diagnostic methods lead to impersonal diagnoses; the great armamentarium of specific therapies lead to an impersonal mode of therapy. It is quite clear that a patient is not a patient unless he has a disease; and needs no care once the disease is eradicated. The mapping of the human genome and its genetic engineering which will follow cannot but further depersonalize the traditional practice of medicine even for the primary physician.

Altschule means "old school". Bedside medicine as it is traditionally and intuitively perceived may be unrecognizably altered by our explosive knowledge and techniques. What will not change however is the basic intellectual curiosity which Whitehead has called the "romance of learning" in the search for knowledge. This,

the ideal physician in the future must have, even when at the bedside he examines a patient not with a vestige of antiquity in the form of a stethoscope but with a print-out of his patient's genome and its deviations. "What Medicine is About" is a physician's intellectual curiosity and never-ending search for a knowledge of Man in his totality.

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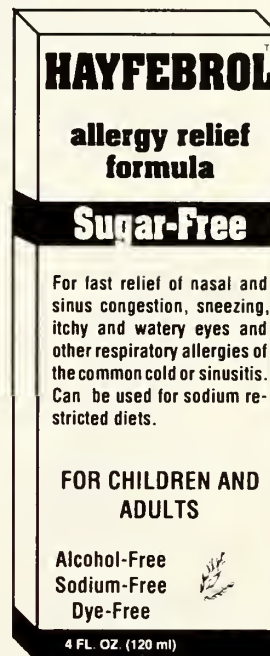
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